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## Workers' Compensation Commission

#### Memorandum

To:

Commissioner Andrea C. Roche, Chairman

Commissioner Susan S. Barden Commissioner G. Bryan Lyndon Commissioner David W. Huffstetler Commissioner Derrick L. Williams Commissioner Avery B. Wilkerson, Jr.

Commissioner T. Scott Beck

Gary M. Cannon, Executive Director

From:

Gary R. Thibault

Date:

September 18, 2009

Subject:

2010 Medical Services Provider Manual

The Medical Services Provider Manual, developed, approved and published by the Commission, sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. The Commission published the first fee schedule in 1950, the last in 2003. (See Attachment 1: 2003 Medical Services Provider Manual.) Until 1995, the fee schedule was charge based. That is, prices were based on an informal survey of physicians' charges for various procedures and discounted. Since 1995, prices have been based on the resources necessary to provide the service.

Development of the 2010 Medical Services Provider Manual included collection and analysis of utilization data for 2008, review of new procedures, review of changes in relative values, and comparison of the Medical Services Provider Manual with fee schedules in other states and with Medicare.

#### **Statutory Authority**

The Workers' Compensation Commission is the regulatory agency of the State of South Carolina responsible for overseeing and administering the South Carolina Workers' Compensation Act. SC Code Ann. §§ 42-1-10 et seq. (1976). The Commission has the authority to approve or deny medical fees, as well as the statutory and regulatory discretion to set the amount of fees. (§ 42-15-90, R 67-1302)

## § 42-15-90. Fees of attorneys and physicians and hospital charges shall be approved by the Commission.

Fees for attorneys and physicians and charges of hospitals for services under this title shall be subject to the approval of the Commission.

#### R 67-1302. Maximum Allowable Payments to Medical Practitioners.

- A. The Commission shall establish maximum allowable payments for medical services provided by medical practitioners based on a relative value scale and a conversion factor set by the Commission.
- (1) The maximum allowable payments and any policies governing the billing and payment of services provided by medical practitioners shall be published in a medical services provider manual.
- (2) The Commission may review and update the relative values and/or conversion factor as needed.

#### **Background & Development Process**

The 2003 Medical Services Provider Manual went into effect on January 1, 2003 and was based on the Centers for Medicare & Medicaid Services (CMS), Resource Based Relative Value Scale (RBRVS). RBRVS, updated and published annually by CMS, establishes a relative value unit for most medical services. (See Attachment 2 for examples of relative values published in the Federal Register, Volume 73, Number 224, Wednesday, November 19, 2008.). Medical services are identified by current procedural terminology (CPT) codes which describe procedures and services performed by physicians and other health care providers. CPT codes are published and updated annually by the American Medical Association. The relative value for each procedure is multiplied by a conversion factor set by the Commission, currently \$52, to arrive at the maximum allowable payment (MAP). MAPs represent the maximum amount that a provider can be paid for rendering services under the Workers' Compensation Act. In instances where the provider's usual charge is lower than the MAP amount, or where the provider has agreed by contract with an employer or insurance carrier to accept discounts resulting in fees lower than the Commission's MAPs, payment is made at the lower amount.

#### R 67-1302. Maximum Allowable Payments to Medical Practitioners.

C. An employer or insurance carrier may not pay, and a medical practitioner may not accept, more than the maximum allowable payment amounts listed in the provider manual.

RBRVS is a well recognized method for determining price based on the work involved, the expense associated with providing that service, and malpractice insurance costs. RBRVS attempts to ensure that fees are based on the resources used to provide each service. It utilizes one of the most systematic methods for setting price and is a system which has been adopted by commercial insurance carriers and workers' compensation programs in other states. It has broad base support in the business, insurance and medical communities.

In 2003 the Commission approved a 5.0% average increase in prices. Between 1998 and 2002 relative values increased 9.1% and to increase total payments 5% required a decrease in the conversion factor of \$2.03, from \$54.03 to \$52.00. The anesthesia conversion factor was increased to \$24.00, proportionally the same as the Medicare conversion factor for anesthesia and the Medicare conversion factor, 46%.

Since the adoption of RBRVS, the Commission has:

- Added a Pharmacy Section
- Added Pathology & Lab
- Added Durable Medical Equipment
- Established site of service payment differential
- Enhanced the narrative to be more user friendly
- Updated CPT codes.

#### Comments Received

On May 22, 2009, a notice of general public interest was published in the State Register and posted on the Commission's website announcing that the Commission was in the process of reviewing and revising the Medical Services Provider Manual. The notice stated that the next edition of the fee schedule would be a complete revision and include updates to payment policies, billing policies, evaluation and management services, anesthesia, surgery, radiology, pathology and lab services, medicine and injections, physical medicine, special reports and services, supplies and durable medical equipment. The notice invited comments and recommendations. The public hearing was held Friday, June 19, 2009, at the offices of the Commission. It is important to note that a public hearing was not required and was held to provide an additional avenue for comments on the fee schedule. While the Commission's regulations provide the method of determining

prices, new or revised fee schedules are established by a vote of the Full Commission at a monthly business meeting. In addition to Commissioners and staff, nine people attended. Written comments were requested by June 30, 2009, and accepted through August 25, 2009. All comments received, as well as a summary of those comments, and the transcript of the hearing, can be found in Attachment 3.

The Commission has long recognized that it must balance the interests of the employee, business, insurance and medical communities to make sure that workers' compensation patients have access to quality health care services at a reasonable price. In order to maintain this important balance, the Commission assured the medical, business and insurance communities that it was committed to monitoring the financial impact of the schedule and making changes when necessary. While historically the Commission has not committed to a course of action which automatically would recognize annual fee adjustments based on one of the inflation indices, it has committed to an ongoing review of all fee schedules.

#### **Analysis**

The Commission established a data set representing over 381,000 procedures representing \$34.2 million in costs performed for workers' compensation patients in South Carolina during 2008. The data set was provided by two large insurance carriers and one self-insured fund. The data set is considered sufficiently large to be representative of workers' compensation cases in this state. Those companies represent approximately 14% of the South Carolina workers' compensation market. (See Attachment 4, "Effect of Adopting 2009 Relative Values.") Based on this data set, the entire market for all procedures covered under the *Medical Services Provider Manual* is estimated at \$244.3 million for 2008.

While the American Medical Association publishes codes for over 7,000 separate procedures, approximately 1,200 are used in workers' compensation. Of the 1,200, the top 200 procedures represent 80.5% of total expenditures in workers' compensation in our state. While the initial analysis was based on all procedures in the data set, the Commission's final analysis was based on the top 200 codes, which represented, in this data set, approximately \$27.5 million in payments to providers.

#### **How South Carolina Compares to Other States**

Since 1993, the Workers' Compensation Research Institute (WCRI), Cambridge, Massachusetts, has published the most comprehensive studies on workers' compensation

fee schedules. It will soon publish its 2009 report in a series titled "Benchmarks for Designing Workers Compensation Fee Schedules". Those reports, published in 1993, 1994, 1996, and 2002 contain similar findings as found in the most recent 2006 study:

- There are substantial differences in fee schedule rates from state to state. The highest state's fee schedule rates are on average 3.5 times higher than the lowest states fee schedule rates.
- Alaska and Illinois have the highest average fee schedules, while Massachusetts has the lowest average fee schedule.
- The interstate variation is not rationally related to the interstate variation in the expenses that medical providers incur in producing the services.
- Most state fee schedules create financial incentives to underuse primary care
  and overuse invasive and specialty care. A few states avoid this by
  following a reasonably fully transitioned RBRVS and setting similar
  conversion factor across the different services groups within their state.
  (Hawaii, Texas, Washington, Michigan, West Virginia, South Carolina,
  Maine Florida, Massachusetts and Maryland)
- Several states have fee schedules that may be higher than necessary. The
  most likely candidates are state fee schedules that are double or more the
  state's Medicare rates.
- A few states may have fee schedules that are so low as to raise concerns about access to quality care.
- Currently more than half of the 42 states base their workers' compensation fee schedule on the RBRVS system, at least in part.
- Absent information concerning the efficacy of care, and absent information regarding access to care, it is difficult to determine the optimal fee schedule price.

(Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006, Workers Compensation Research Institute, Cambridge, Massachusetts, November 2006)

Establishing rates involves a delicate balance. If fee schedules set prices too high, savings will be negligible and the goal of medical cost containment will not be met. If fees are set too low, fewer providers will elect to treat workers' compensation patients and

access to quality care may be affected. It has been the public policy of most states, including South Carolina, since workers' compensation insurance is required of most employers, with the cost ultimately paid by all citizens of the state as part of the price of goods and services they purchase, that medical costs be contained as are other costs in workers' compensation, including disability and wage loss. Forty-three jurisdictions have implemented workers' compensation medical fee schedules, the tool most often used to contain medical costs.

#### WCRI Medical Price Index, MPI-WC

WCRI has developed a medical price index for a market basket of non-hospital, non-facility procedures common in workers' compensation. This market basket is comprised of office visits, consultations, surgery, radiology and physical medicine and includes approximately 80% to 90% of all non-hospital expenditures. The report quantifies the relative prices paid for workers' compensation medical care in 25 states as well as the trend in prices paid in those states. The study, published in June 2008, tracks price changes from 2001 to 2006 and includes South Carolina, North Carolina and Georgia among the states studied. It also tracks changes in prices paid within those states and allows for interstate comparisons.

Based on WCRI's analysis, in 2006 South Carolina had a price index of 90, that is, the prices paid in South Carolina were 10% lower than the prices paid in the median state. North Carolina also had a fee index of 90 and Georgia had a price index of 100. The three lowest states were Maryland, Texas and New York with indices of 76, 82 and 86 respectively. The highest were Wisconsin, Illinois and New Jersey with indices of 195, 161 and 144. (See Attachment 5, *Medical Price Index for Workers' Compensation: The MPI-WC, Second Edition, June 2008*, Workers Compensation Research Institute, Cambridge, Massachusetts.)

WCRI also measured the difference between prices set in each state for workers' compensation purposes and those set for Medicare. Medicare, which is a major payer of medical services in all states, adjusts prices in each state according to the differences in the cost of providing medical treatment. It is one of the few national payers what has designed a system that adjusts prices based on a geographical practice cost index. (See Attachment 6, 2009 Geographic Adjustment Factors; and 2009 Geographic Practice Cost Indices by State and Medicare Locality.) Thus the prices Medicare sets and pays for services provided in Alabama, for example, differ than the prices set for Alaska. This allows comparison between states, not only of Medicare prices but the comparison of the prices set by other payers as well. For example, by using Medicare as the baseline, the percentage difference in what each state pays in relation to Medicare provides another benchmark to compare workers' compensation fees. According to WCRI, South Carolina's *Medical Services* 

*Provider Manual*, on average sets, as of July 2006, prices 47% higher than Medicare. North Carolina sets fees 39% higher than Medicare and Georgia 58% higher.

The three lowest states were Massachusetts, Hawaii and West Virginia. Massachusetts fees, on average, were 13% below Medicare prices and Hawaii's workers' compensation fee schedule was 10% above Medicare. West Virginia was 13% higher than Medicare's. The three highest states, Alaska, Illinois, and Rhode Island set fees 236%, 163% and 116% higher than Medicare. (See Attachment 7: "Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule, by Service Group, July 2006".)

#### Inflation

Since January 2003, the date of the last overall increase in medical fees, the Consumer Price Index for Medical Care, in cities with populations between 50,000 and 1,500,000 in the South, increased 26.8% (January 2003 through July 2009). Over this same period of time the price for medical care services increased 28.9% for urban areas in the South. The Consumer Price Index for all items increased 17.6% during this period. (See Attachment 8, Bureau of Labor Statistics, Consumer Price Index.)

Another measure of change in the cost of physician services is the Medicare Economic Index (MEI). The MEI measures the average annual price change for various inputs need to produce physician services. It is comprised of two categories: the physician's own time, to include wages, salaries and fringe benefits, and the physicians practice expense. The physicians practice expense includes nonphysician employee compensation, office expense, drugs and medical supplies, liability insurance costs, medical equipment and other expenses. The MEI is adjusted to reflect productivity growth.

The MEI is projected to increase 1.6% in 2009 after having increased 15.7% from 2003 to 2008 for a total increase of 17.3% during this period. (See Attachment 9, "Increase in the Medicare Economic Index Update for CY 2009", Attachment 10, "Medicare Economic Index, 2003 – 2009" and Attachment 11, "Medicare Economic Index & CPI, 2003 – 2009.")

#### Pharmacy

In 2003, based on recommendations from its Pharmacy Advisory Committee, the Commission included a pharmacy section as part of the fee schedule. Payment for prescription drugs, both brand name and generic, is limited to the average wholesale price plus a \$5.00 dispensing fee or the pharmacist's or health care provider's usual and

customary charge, whichever is less. The *Red Book*, published by Thomson Reuters, and the *Blue Book*, published by First Databank, are the sources of average wholesale prices. All prescriptions must be filled using generic drugs, if available, unless the treating physician directs otherwise.

It is important to note that average wholesale price is not equivalent to acquisition cost. It is a price determined by manufacturers. Pharmacies receive substantial discounts and rebates to average wholesale price and there is considerable variation in the discounts and rebates received.

While the payments under this formula are higher than some health insurance plans, our payment system is not as fluid, with a substantially higher number of payers involved and slightly higher transaction costs. The fee schedule amount is the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer or insurance carrier to accept discounts or lower fees, payment is to be made at the lower amount.

While no change is being recommended in the prescription pricing formula, it is an issue that will need further consideration as a result of ongoing national litigation over the method for calculating average wholesale prices. (For example, see New England Carpenters Health Benefits Fund et. al. v. First Data Bank, Inc., and McKesson Corporation. As a result of \$350 million settlement in this class action lawsuit, in two years First Databank will no longer publish the *Blue Book*. See Attachment 12, "Settlement to Reduce Brand-Name Drug Prices in Many States", Workcompcentral, September 9, 2009.) In addition, there are changes underway in Medicare's pricing of drugs, specifically, changes in how prescription drugs will be priced for inclusion in set-aside agreements.

#### Recommendations for 2010

Based on this analysis, the following is recommended: a 3.1% average increase in prices for 2010, adoption of CMS's 2009 relative values, to include facility and non-facility relative values where applicable, and inclusion of the most recent current procedural codes published by the American Medical Association. Between 2003 and 2009 relative values increased 3.1% (See Attachment 4, Effect of Adopting 2009 Relative Values). To increase total payments 3.1%, the conversion factor would remain \$52.00. The anesthesia conversion factor would be \$30.00, proportionally the same as the Medicare conversion factor for anesthesia and the Medicare conversion factor, 58%. The current anesthesia

conversion factor is \$24.00. The 26% increase in the anesthesia conversion factor is a result of changes implemented by Medicare since 2002.

#### **Independent Medical Examinations**

It is recommended that the fee for an independent medical examination be increased from \$600 to \$750. The American Medical Association defines an independent medical examination, CPT Code 99456, as a work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition, performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report. It is also recommended that CPT Code 99455, impairment rating by the treating physician, be increased from \$97 to \$150. With this change, it is recommended that in extenuating or complex circumstances, an IME fee greater than the maximum allowable payment may be approved, either by a commissioner or through administrative review by the Commission's Medical Services Division. Appropriate supporting documentation must be submitted with the request.

The following changes in fees are also recommended:

- CPT Code 99075, Medical testimony, physician, first hour from \$536 to \$600;
- CPT Code 99076, Medical testimony, physician, each additional quarter hour from \$134 to \$150;
- CPT Code 99145, Testimony by deposition, physician first hour from \$320 to \$400; and
- CPT Code 99146, Testimony by deposition, physician, each additional quarter hour, from \$80 to \$100.

For all other fees where a relative value is not available, the price will be calculated in the same manner as the 2003 schedule or the increase will be same as the overall increase approved.

#### **National Correct Coding Initiative**

It is also recommended that the National Correct Coding Initiative be cited and used to guide the billing and payment of procedures. This coding initiative was developed by the Centers for Medicare and Medicaid Services to promote correct coding of health services and prevent payment for improperly coded services. It consists of edits to evaluate claims when a provider bills more than one service for the same patient for the same date of service. It is based on coding conventions in the American Medical Associations

Current Procedural Terminology manual, coding guidelines from national societies and analysis of Medicare medical and surgical practices. Its purpose is to ensure that the most comprehensive group of codes are billed rather than the component parts and to edit two codes that cannot reasonably be performed together based on either the definition or anatomical considerations. It is a national recognized system used by Medicare since 1996, many state Medicaid programs and many health insurance carriers. The Commission for many years has used the correct coding edits as a basis for resolving bill disputes. It provides a system to determine which procedures are part of, and thus included in the payment of, the same service. The recommendation is to include a statement in the fee schedule citing its use thus providing greater clarification and guidance for proper billing and payment. If any disputes arise concerning proper coding, the dispute can be handled in the same manner as provided by R67-1305, Medical Bill Review.

The effective date of the new schedule would be January 1, 2010, or as soon thereafter as possible.

#### Impact on Total Payments & Premium

The National Council on Compensation Insurance (NCCI) estimates that the adoption of Medicare's 2009 relative values and the change in the anesthesia conversion factor would result in a 3.8% increase in physician costs. The dollar impact on overall workers' compensation system costs would be \$7.6 million. (See Attachment 13, "Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010", National Council on Compensation Insurance, September 17, 2009.)

#### GRT:t

#### Attachments

- 1. 2003 Medical Services Provider Manual
- 2. Federal Register, Vol. 73, No 224, Wednesday, November 19, 2008
- 3. Summary of Comments Received, Comments Received and Public Hearing Transcript
- 4. Effect of Adopting 2009 Relative Values
- 5. WCRI Medical Price Index For Workers' Compensation: The MPI-WC, Second Edition
- 6. 2009 Geographic Adjustment Factors; 2009 Geographic Practice Cost Indices by State and Medicare Locality
- 7. "Workers' Compensation Premium Over Medicare by Service Group, July 2006"

- 8. Bureau of Labor Statistics, Consumer Price Index
- 9. "Increase in the Medicare Economic Index Update for CY 2009"
- 10. "Medicare Economic Index, 2003 2009"
- 11. "Medicare Economic Index and CPI, 2003 2009"
- 12. "Settlement to Reduce Brand-Name Drug Prices in Many States", Workcompoentral, September 1, 2009.
- 13. "Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010", National Council on Compensation Insurance, Inc., September 17, 2009.

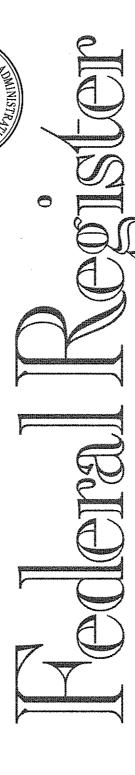
### Attachment 1

2003 Medical Services Provider Manual

(Bound in separate binder)

### Attachment 2

Example of Relative Values
Selected Pages
Federal Register, Volume 73, Number 224
Wednesday, November 19, 2008



Wednesday, November 19, 2008

Book 2 of 2 Books Pages 69725–70238

### Part II

## Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, et al.

Medicare Program; Payment Policies
Under the Physician Fee Schedule and
Other Revisions to Part B for CY 2009;
E-Prescribing Exemption for ComputerGenerated Facsimile Transmissions; and
Payment for Certain Durable Medical
Equipment, Prosthetics, Orthotics, and
Supplies (DMEPOS); Final Rule

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, 410, 411, 413, 414, 415, 423, 424, 485, 486, and 489

[CMS-1403-FC] [CMS-1270-F2]

RINs 0938-AP18, 0938-AN14

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

**SUMMARY:** This final rule with comment period implements changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It also finalizes the calendar year (CY) 2008 interim relative value units (RVUs) and issues interim RVUs for new and revised codes for CY 2009. In addition, as required by the statute, it announces that the physician fee schedule update is 1.1 percent for CY 2009, the preliminary estimate for the sustainable growth rate for CY 2009 is 7.4 percent, and the conversion factor (CF) for CY 2009 is \$36.0666. This final rule with comment period also implements or discusses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). (See the Table of Contents for a listing of the specific issues addressed in this rule.) DATES: Effective Date: This final rule with comment period is effective on January 1, 2009 except for amendments to § 410.62 and § 411.351 which are effective July 1, 2009.

Comment Date: Comments will be considered if we receive them at one of the addresses provided below, no later than 5 p.m. e.s.t. on December 29, 2008.

ADDRESSES: In commenting, please refer to file code CMS-1403-FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX)

transmission.

You may submit comments in one of four ways (no duplicates, please):

1. Electronically. You may submit electronic comments on this regulation

to http://www.regulations.gov. Follow the instructions for "Comment or Submission" and enter the filecode to find the document accepting comments.

2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1403-FC, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1403-FC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

7500 Security Boulevard, Baltimore, MD 21244–1850; or

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the SUPPLEMENTARY INFORMATION SECTION. FOR FURTHER INFORMATION CONTACT:

Pam West, (410) 786–2302, for issues related to practice expense.

Rick Ensor, (410) 786-5617, for issues related to practice expense methodology.

Stephanie Monroe, (410) 786–6864, for issues related to malpractice RVUs.

Esther Markowitz, (410) 786–4595, for issues related to telehealth services.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices.

Ken Marsalek, (410) 786–4502, for issues related to the multiple procedure payment reduction for diagnostic imaging.

Catherine Jansto, (410) 786–7762, or Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

Corinne Axelrod, (410) 786–5620, for issues related to Health Professional Shortage Area Bonus Payments.

Henry Richter, (410) 786–4562, for issues related to payments for end-stage renal disease facilities.

Lisa Grabert, (410) 786–6827, for issues related to hospital-acquired conditions and the Physician Resource

Use Feedback Program.
August Nemec, (410) 786–0612, for issues related to independent diagnostic testing facilities; enrollment issues; and the revision to the "Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges" final rule.

Lisa Ohrin, (410) 786–4565, Kristin Bohl, (410) 786–8680, or Don Romano, (410) 786–1401, for issues related to anti-markup provisions and physician self-referral (incentive payment and shared savings programs).

Diane Stern, (410) 786–1133, for issues related to the quality reporting system for physician payment for CY 2009.

Andrew Morgan, (410) 786–2543, for issues related to the e-prescribing exemption for computer-generated fax transmissions.

Terri Harris, (410) 786–6830, for issues related to payment for comprehensive outpatient rehabilitation facilities (CORFs).

Lauren Oviatt, (410) 786–4683, for issues related to CORF conditions of coverage.

Trisha Brooks, (410) 786–4561, for issues related to personnel standards for portable x-ray suppliers.

David Walczak, (410) 786–4475, for

David Walczak, (410) 786–4475, for issues related to beneficiary signature for nonemergency ambulance transport services.

Jean Stiller, (410) 786–0708, for issues related to the prohibition concerning providers of sleep tests Mark Horney, (410) 786–4554, for

Mark Horney, (410) 786–4554, for issues related to the solicitation for comments and data pertaining to physician organ retrieval services.

Regina Walker-Wren, (410) 786–9160, for information concerning educational

requirements for nurse practitioners and clinical nurse specialists.

Randy Throndset, (410) 786-0131, for information concerning physician certification and recertification for Medicare home health services.

William Larson, (410) 786-4639, for coverage issues related to the initial preventive physical examination.

Cathleen Scally, (410) 786-5714, for payment issues related to the initial preventive physical examination.

Dorothy Shannon, (410) 786-3396, for issues related to speech language pathology.

Kendra Hedgebeth, (410) 786-4644, or Gina Longus, (410) 786-1287, for issues related to low vision aids.

Christopher Molling, (410) 786-6399, or Anita Greenberg, (410) 786-4601, for issues related to the repeal to transfer of title for oxygen equipment.

Karen Jacobs, (410) 786-2173, or Hafsa Bora, (410) 786-7899, for issues related to the therapeutic shoes fee schedule.

Diane Milstead, (410) 786-3355, or Gaysha Brooks, (410) 786-9649, for all other issues.

#### SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues:

- The Exception for Incentive Payment and Shared Savings Programs (§ 411.357(x)) in section II.N.1. of this final rule with comment period;
- Sections 131(c), 144(b), and 149 of the MIPPA as described in sections III.C., III.J., and III.M. of this final rule with comment period.
- Interim Relative Value Units (RVUs) for selected codes identified in Addendum C;
- · Information on pricing for items in Tables 2 through 5;
- · Issues related to the Physician Resource Use Feedback Program described in section II.S.6. of this final rule with comment period; and
- The physician self-referral designated health services (DHS) codes listed in Tables 29, 30, and 31. You can assist us by referencing the file code [CMS-1403-FC] and the section heading on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://

www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

#### **Table of Contents**

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the Code of Federal Regulations (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not exclusively in section XVI. of this final rule with comment

- I. Background
  - A. Development of the Relative Value
  - 1. Work RVUs
  - 2. Practice Expense Relative Value Units (PE RVUs)
  - 3. Resource-Based Malpractice RVUs
  - 4. Refinements to the RVUs
  - 5. Adjustments to RVUs are Budget Neutral
  - B. Components of the Fee Schedule Payment Amounts
- C. Most Recent Changes to Fee Schedule
- II. Provisions of the Proposed Regulation A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
- Current Methodology
- 2. PE Proposals for CY 2009
- B. Geographic Practice Cost Indices (GPČIs): Locality Discussion
- C. Malpractice RVUs (TC/PC issue)
- D. Medicare Telehealth Services
- E. Specific Coding Issues Related to Physician Fee Schedule
- 1. Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin
- Multiple Procedure Payment Reduction for Diagnostic Imaging
  3. HCPCS Code for Prostate Saturation
- Biopsies
- F. Part B Drug Payment
- 1. Average Sales Price (ASP) Issues
- 2. Competitive Acquisition Program (CAP)
- G. Application of the HPSA Bonus Payment
- H. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities
- I. Independent Diagnostic Testing Facility (IDTF) Issues
- J. Physician and Nonphysician Practitioner (NPP) Enrollment Issues

- K. Amendment to the Exemption for Computer-Generated Facsimile (FAX) Transmissions From the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard for Transmitting Prescription and Certain Prescription-Related Information for Part D Covered Drugs Prescribed for Part D Eligible Individuals
- L. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues
- M. Technical Corrections for Therapy-Related Issues
- N. Physician Self-Referral and Anti-Markup Issues
- 1. Exception for Incentive Payment and Shared Savings Programs (§ 411.357(x))
- 2. Changes to Reassignment Rules Related to Diagnostic Tests (Anti-Markup
- O1. Physician Quality Reporting Initiative
- O2. Electronic Prescribing (E-Prescribing) Incentive Program
- P. Discussion of Chiropractic Services Demonstration
- Q. Educational Requirements for Nurse Practitioners and Clinical Nurse Specialists
- R. Portable X-Ray Issue
- S. Other Issues
- 1. Physician Certification (G0180) and Recertification (G0179) for Medicare-Covered Home Health Services Under a Home Health Plan of Care (POC) in the Home Health Prospective Payment System (HH PPS)
- 2. Prohibition Concerning Payment of Continuous Positive Airway Pressure (CPAP) Devices
- 3. Beneficiary Signature for Nonemergency Ambulance Transport Services
- 4. Solicitation of Comments and Data Pertaining to Physician Organ Retrieval
- 5. Revision to the "Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges" Final Rule
- 6. Physician Resource Use Feedback Program
- T. Electronic Prescribing (E-Prescribing) Incentive Program
- III. Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) **Provisions** 
  - A. Section 101: Improvements to Coverage of Preventive Services
  - B. Section 131: Physician Payment, Efficiency, and Quality Improvements
  - C. Section 131(c): Physician Resource Use Feedback Program
  - D. Section 132: Incentives for Electronic Prescribing
  - E. Section 133(b); Expanding Access to Primary Care Services
- F. Section 134: Extension of Floor on Medicare Work Geographic Adjustment Under the Medicare Physician Fee Schedule
- G. Section 136: Extension of Treatment of Certain Physician Pathology Services Under Medicare
- H. Section 141: Extension of Exceptions Process for Medicare Therapy Caps

- I. Section 143: Speech-Language Pathology
- J. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment K. Section 145: Clinical Laboratory Tests
- L. Section 146: Improved Access to
- Ambulance Services M. Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth Services
- N. Section 153: Renal Dialysis Provisions IV. Potentially Misvalued Codes Under PFS A. Valuing Services Under the Physician
  - Fee Schedule B. Requested Approaches for the AMA RUC To Utilize
  - C. AMA RUC Review of Potentially Misvalued Codes
- V. Refinement of Relative Value Units for Calendar Year 2009 and Response to Public Comments on Interim Relative Value Units for 2008
  - A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units
  - B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule
  - C. Interim 2008 Codes
  - D. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2009 (Includes Table Titled "AMA RUC Recommendations and CMS' Decisions for New and Revised 2009 CPT Codes")
- E. Discussion of Codes and AMA RUC Recommendations
- F. Additional Coding Issues
- G. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2009
- VI. Physician Self-Referral Prohibition: Annual Update to the List of CPT/ **HCPCS Codes** 
  - A. General
- B. Speech-Language Pathology Services C. Annual Update to the Code List
- VII. Physician Fee Schedule Update for CY
  - A. Physician Fee Schedule Update
- B. The Percentage Change in the Medicare Economic Index (MEI)
- C. The Update Adjustment Factor (UAF) VIII. Allowed Expenditures for Physicians' Services and the Sustainable Growth
  - Rate (SGR) A. Medicare Sustainable Growth Rate
  - B. Physicians' Services
  - C. Preliminary Estimate of the SGR for
  - D. Revised Sustainable Growth Rate for
- E. Calculation of 2009, 2008, and 2007 Sustainable Growth Rates
- IX. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2009
- A. Physician Fee Schedule Conversion Factor
- B. Anesthesia Conversion Factor
- X. Telehealth Originating Site Facility Fee Payment Amount Update
- XI. Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and

- Supplies (DMEPOS)—Services Excluded From Coverage
- A. Low Vision Aid Exclusion
- B. Replacement of Reasonable Charge Methodology by Fee Schedules for Therapeutic Shoes
- XII. Provisions of the Final Rule
- XIII. Waiver of Proposed Rulemaking and Delay in Effective Date
- XIV. Collection of Information Requirements XV. Response to Comments
- XVI. Regulatory Impact Analysis Regulation Text
- Addendum A—Explanation and Use of Addendum B
- Addendum B-Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2009
- Addendum C—Codes With Interim RVUs Addendum D—2009 Geographic Adjustment Factors (GAFs)
- Addendum E-2009 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality
- Addendum F-Multiple Procedure Payment Reduction Code List
- Addendum G—CY 2009 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas
- Addendum H-CY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas
- Addendum I—CPT/HCPCS Imaging Codes Defined by Section 5102(b) of the DRA
- Addendum J-List of CPT/HCPCS Codes Used To Define Certain Designated Health Services Under Section 1877 of the Social Security Act

#### Acronyms

In addition, because of the many organizations and terms to which we refer by acronym in this final rule with comment period, we are listing these acronyms and their corresponding terms in alphabetical order below:

- ACC American College of Cardiology ACR American College of Radiology AFROC Association of Freestanding Radiation Oncology Centers
- AHA American Heart Association AHRQ [HHS] Agency for Healthcare Research and Quality
- AIDS Acquired immune deficiency syndrome
- AMA American Medical Association AMP
- Average manufacturer price American Osteopathic Association AOA
- ASC Ambulatory surgical center ASP Average sales price
- ASRT American Society of Radiologic Technologists
- ASTRO American Society for Therapeutic Radiology and Oncology
- ATA American Telemedicine Association Average wholesale price AWP
- BBA Balanced Budget Act of 1997 (Pub. L. 105-33)
- BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113)
- BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106-554)

- Bureau of Labor Statistics
- BN Budget neutrality
- CABG Coronary artery bypass graft
- CAD Coronary artery disease CAH Critical access hospital
- CAHEA Committee on Allied Health
- Education and Accreditation CAP Competitive acquisition program
- CBSA Core-Based Statistical Area CCHIT Certification Commission for
- Healthcare Information Technology CEAMA Council on Education of the
- American Medical Association
- Conversion factor CfC Conditions for Coverage
- CFR Code of Federal Regulations
- CKD Chronic kidney disease
- CLFS Clinical laboratory fee schedule
- California Medical Association CMA CMHC Community mental health center
- Civil money penalty Centers for Medicare & Medicaid CMP
- CMS Services
- CNS Clinical nurse specialist CoP Condition of participation
- CORF Comprehensive Outpatient Rehabilitation Facility
- CPAP Continuous positive air pressure
- CPEP Clinical Practice Expert Panel CPI Consumer Price Index
- CPI-U Consumer price index for urban customers
- CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
- CRT Certified respiratory therapist
- CSW Clinical social worker CY Calendar year
- DHS Designated health services
- DME Durable medical equipment DMEPOS Durable medical equipment,
- prosthetics, orthotics, and supplies
- DNP Doctor of Nursing Practice
  DRA Deficit Reduction Act of 2005 (Pub. L. 109-171)
- DSMT Diabetes self-management training
- E/M Evaluation and management
- EDI Electronic data interchange
- Electroencephalogram
- EHR Electronic health record
- EKG Electrocardiogram
- EMG Electromyogram
- EMTALA Emergency Medical Treatment and Active Labor Act
- EOG Electro-oculogram
- EPO Erythopoeitin
- ESRD End-stage renal disease
- FAX Facsimile
- Food and Drug Administration (HHS)
- Fee-for-service
- [Department of the Treasury's] **FMS**
- Financial Management Service
- FPLP Federal Payment Levy Program
- FR Federal Register GAF Geographic adjustment factor
- General Accounting Office GAO
- GPO Group purchasing organization
- **GPCI** Geographic practice cost index
- Hospital-acquired conditions HCPAC Health Care Professional Advisory
- Committee HCPCS Healthcare Common Procedure Coding System
- HCRIS Healthcare Cost Report Information System

HH PPS Home Health Prospective Payment System HHA Home health agency HHRG Home health resource group HHS [Department of] Health and Human Services HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-HIT Health information technology HITSP Healthcare Information Technology Standards Panel HIV Human immunodeficiency virus HOPD Hospital outpatient department HPSA Health Professional Shortage Area HRSA Health Resources Services Administration (HHS) ICF Intermediate care facilities ICR Information collection requirement IDTF Independent diagnostic testing facility Interim final rule with comment period IPPS Inpatient prospective payment system IRS Internal Revenue Service IVIG Intravenous immune globulin IWPUT Intra-service work per unit of time JRCERT Joint Review Committee on Education in Radiologic Technology MA Medicare Advantage MA-PD Medicare Advantage-Prescription Drug Plans MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC)) MedPAC Medicare Payment Advisory Commission MEI Medicare Economic Index MIEA-TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109-432) MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173) MNT Medical nutrition therapy MP Malpractice MPPR Multiple procedure payment reduction MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539) MRA Magnetic resonance angiography MRI Magnetic resonance imaging MS-DRG Medicare Severity-Diagnosis related group MSA Metropolitan statistical area NCD National Coverage Determination NCPDP National Council for Prescription Drug Programs NDC National drug code NISTA National Institute of Standards and Technology Act NP Nurse practitioner NPDB National Practitioner Data Bank NPI National Provider Identifier NPP Nonphysician practitioner NPPES National Plan and Provider **Enumeration System** NQF National Quality Forum NRC Nuclear Regulatory Commission NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104-113)

National Uniform Billing Committee OACT [CMS'] Office of the Actuary OBRA Omnibus Budget Reconciliation Act ODF Open door forum OIG Office of Inspector General OMB Office of Management and Budget [HHS'] Office of the National Coordinator for Health Information Technology OPPS Outpatient prospective payment system OSA Obstructive Sleep Apnea OSCAR Online Survey and Certification and Reporting P4P Pay for performance PΑ Physician assistant PC Professional component PCF Patient compensation fund PDP Prescription drug plan PE Practice expense PE/HR Practice expense per hour PEAC Practice Expense Advisory Committee PECOS Provider Enrollment, Chain, and Ownership System PERC Practice Expense Review Committee Physician Fee Schedule PHP Partial hospitalization program [Medicare] Program Integrity Manual PIMPLIProfessional liability insurance POA Present on admission POC Plan of care PPI Producer price index PPS Prospective payment system PPTA Plasma Protein Therapeutics Association PQRI Physician Quality Reporting Initiative PRA Paperwork Reduction Act PSA Physician scarcity areas PSG Polysomnography PT Physical therapy ResDAC Research Data Assistance Center RFA Regulatory Flexibility Act RIA Regulatory impact analysis RN Registered nurse RNAC Reasonable net acquisition cost RRT Registered respiratory therapist RUC [AMA's Specialty Society] Relative (Value) Update Committee RVU Relative value unit SBA Small Business Administration SGR Sustainable growth rate SLP. Speech-language pathology SMS [AMA's] Socioeconomic Monitoring System SNF Skilled nursing facility SOR System of record Stereotactic radiosurgery SRS TC Technical Component TIN Tax identification number TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109-432) UPMC University of Pittsburgh Medical Center USDE United States Department of Education VBP Value-based purchasing WAMP Widely available market price

#### I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges.

A. Development of the Relative Value System

#### 1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide. We established a separate conversion factor (CF) for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but

excluding malpractice expenses)

comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physician's service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices,

data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the Federal Register (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In CY 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology. We will continue to evaluate this policy and proposed necessary revisions through future rulemaking.

### 3. Resource-Based Malpractice (MP)

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

#### 4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first 5-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second 5-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third 5-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (Note: Additional codes relating to the third 5-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new methodology for determining resource-based PE RVUs and are transitioning this over a 4-year period.

this over a 4-year period.

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first 5-Year Review of the MP RVUs (69 FR 66263).

#### 5. Adjustments to RVUs are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than \$20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if adjustments to RVUs cause expenditures to change by more than \$20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than \$20 million.

As explained in the CY 2007 PFS final rule with comment period (71 FR 69624), due to the increase in work RVUs resulting from the third 5-Year Review of physician work RVUs, we applied a separate budget neutrality (BN) adjustor to the work RVUs for services furnished during 2007 and 2008. This approach is consistent with the method we used to make BN adjustments to reflect the changes in the PE RVUs.

Section 133(b) of the MIPPA amends section 1848(c)(2)(B) of the Act to specify that, instead of continuing to apply the BN adjustor for the 5-Year Review to work RVUs, the BN adjustment must be applied to the CF for years beginning with CY 2009. Further discussion of this MIPPA provision as it relates to the CY 2009 PFS can be found in sections III. and IX. of this final rule with comment period.

#### B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physician's service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice insurance in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which

CPT¹/ HCPCS	Mod	Status	Description	Physi- cian Work RVUs <sup>2</sup>	Fully Imple- mented Non- Facility PE RVUs <sup>2</sup>	Year 2009 Transi- tional Non- Facility PE RVUs <sup>2</sup>	Fully Imple- mented Facility PE RVUs <sup>2</sup>	Year 2009 Transi- tional Facility PE RVUs <sup>2</sup>	Mal- Practice RVUs <sup>2</sup>	Global
22226	11100	A	Revise, extra spine segment	6.03	NA	NA NA	2.45	2.62	1.29	ZZZ
22305		A	Treat spine process fracture	2.08	2.15	2.20	1.82	1.85	0.39	090
22310		A	Treat spine fracture	3.69	3.05	2.99	2.57	2.52	0.50	090
22315		A	Treat spine fracture	9.91	9.79	9.79	7.49	7.47	1.86	090
22318		A	Treat odontoid fx w/o graft	22,54	NA	NA	13.45	13.47	5.30	090
22319		Α	Treat odontoid fx w/graft	25.15	NA	NA	14.07	14.26	6.05	090
22325		Α	Treat spine fracture	19.62	NA	NA	12.52	12,44	3.88	090
22326		Α	Treat neck spine fracture	20.64	NA	NA	12.40	12.51	4.43	090
22327		Α	Treat thorax spine fracture	20.52	NA	NA	12.70	12.65	3.99	090
22328		Α	Treat each add spine fx	4.60	NA	NA	1.87	1.97	0.94	ZZZ
22505		Α	Manipulation of spine	1.87	NA	NA	0.97	0.96	0.36	010
22520		Α	Percut vertebroplasty thor	9.17	42.10	47.11	4.27	4.48	1.72	010
22521		Α	Percut vertebroplasty lumb	8.60	42.89	46.27	4.04	4.28	1.60	010
22522		Α	Percut vertebroplasty addÆl	4.30	NA	NA	1.66	1.67	0.82	ZZZ
22523		Α	Percut kyphoplasty, thor	9.21	NA	NA	4.87	5.14	1.72	010
22524		Α	Percut kyphoplasty, lumbar	8.81	NA	NA	4.71	4.97	1.60	010
22525		Α	Percut kyphopiasty, add-on	4.47	NA	NA	1.80	1.92	0.82	ZZZ
22526		Α	Idet, single level	6.07	41.57	41.57	1.91	1.91	1.16	010
22527		Α	Idet, 1 or more levels	3.03	34.18	34.18	0.57	0.57	0.58	ZZZ
22532		Α	Lat thorax spine fusion	25.81	NA	NA	14.22	14.41	4.35	090
22533		Α	Lat lumbar spine fusion	24.61	NA	NA	13.99	13.92	3.16	090
22534		Α	Lat thor/lumb, addÆl seg	5.99	NA	NA	2.45	2.60	1.25	ZZZ
22548		Α	Neck spine fusion	26.86	NA	NA	15.10	15.31	5.61	090
22554		Α	Neck spine fusion	17.54	NA	NA	10.87	11.26	4.46	090
22556		A	Thorax spine fusion	24.50	NA	NA	13.36	13.73	4.35	090
22558		Α	Lumbar spine fusion	23.33	NA	NA	12.01	12.36	3.16	090
22585		A	Additional spinal fusion	5.52	NA	NA	2.19	2.35	1.25	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	NA	13.38	13.40	4.79	090
22595		A	Neck spinal fusion	20.44	NA	NA	12.82	12.85	4.41	090
22600		A	Neck spine fusion	17.20	NA	NA	11.41	11.38	3.73	090
22610		A	Thorax spine fusion	17.08	NA	NA	11.14	11.23	3.53	090
22612		A	Lumbar spine fusion	23.38	NA	NA	12.99	13.32	4.47	090
22614		A	Spine fusion, extra segment	6.43	NA NA	NA NA	2.62	2.81	1.38	ZZZ
22630 22632		A A	Lumbar spine fusion Spine fusion, extra segment	21.89 5.22	NA NA	NA NA	12.91 2.11	13.12 2.26	4.73 1.16	090 <b>ZZZ</b>
22800		A	Fusion of spine	19.30	NA.	NA.	11.60	11.92	3.76	090
22802		A	Fusion of spine	31.91	NA.	NA.	16.85	17.58	6.17	090
22804		A	Fusion of spine	37.30	NA	NA	18.97	19.95	7.00	090
22808		A	Fusion of spine	27.31	NA	NA	14.53	15.01	4.93	090
22810		A	Fusion of spine	31.30	NA	NA	15.32	16.12	5.15	090
22812		A	Fusion of spine	34.00	NA	NA	17,43	18.13	5.30	090
22818		A	Kyphectomy, 1-2 segments	34.18	NA	NA	17.12	17.60	6.47	090
22819		A	Kyphectomy, 3 or more	39.18	NA	NA	20.36	20.33	7.67	090
22830		A	Exploration of spinal fusion	11.13	NA	NA	7.26	7.45	2.30	090
22840		A	Insert spine fixation device	12.52	NA	NA	5.09	5.45	2.79	ZZZ
22841		В	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		Ā	Insert spine fixation device	12.56	NA	NA	5.12	5.48	2.75	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	5.53	5.81	2.86	ZZZ
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 $<sup>1\</sup> CPT$  codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

<sup>2</sup> If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

CPT¹/				Physi- cian Work	Fully Imple- mented Non- Facility PE	Year 2009 Transi- tional Non- Facility PE	Fully Imple- mented Facility PE	Year 2009 Transi- tional Facility PE	Mal- Practice	
HCPCS	Mod	Status	Description	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	Global
29580	17200	A	Application of paste boot	0.55	0.70	0.69	0.33	0.34	0.07	000
29590		A	Application of foot splint	0.76	0.58	0.56	0.26	0.27	0.09	000
29700		A	Removal/revision of cast	0.57	0.94	0.93	0.26	0.27	0.08	000
29705		Ā	Removal/revision of cast	0.76	0.78	0.79	0.38	0.38	0.13	000
29710		A	Removal/revision of cast	1.34	1.34	1.39	0.61	0.63	0.20	000
29715		A	Removal/revision of cast	0.94	1.19	1.18	0.46	0.44	0.09	000
29720		A	Repair of body cast	0.68	1.15	1.16	0.36	0.37	0.12	000
29730		A	Windowing of cast	0.75	0.74	0.76	0.35	0.35	0.12	000
29740		A	Wedging of cast	1.12	1.00	1.04	0.48	0.48	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.10	1.09	0.57	0.57	0.21	000
29799		Ċ	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		Ā	Jaw arthroscopy/surgery	6.73	NA	NA	4.98	5.49	0.99	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	NA	5.92	6.36	1.38	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	NA	4.82	5.04	1.02	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	NA	9.70	10.09	2.50	090
29807		Α	Shoulder arthroscopy/surgery	14.48	NA	NA	9.53	9.92	2.42	090
29819		Α	Shoulder arthroscopy/surgery	7.68	NA	NA	5.80	6.06	1.32	090
29820		Α	Shoulder arthroscopy/surgery	7.12	NA	NA	5.32	5.56	1.22	090
29821		Α	Shoulder arthroscopy/surgery	7.78	NA	NA	5.80	6.07	1.33	090
29822		Α	Shoulder arthroscopy/surgery	7.49	NA	NA	5.71	5.97	1.28	090
29823		Α	Shoulder arthroscopy/surgery	8.24	NA	NA	6.21	6.48	1.41	090
29824		Α	Shoulder arthroscopy/surgery	8.82	ÑΑ	NA	6.70	6.92	1.42	090
29825		Α	Shoulder arthroscopy/surgery	7.68	NA	NA	5.78	6.04	1.32	090
29826		Α	Shoulder arthroscopy/surgery	9.05	NA	NA	6.37	6.67	1.55	090
29827		Α	Arthroscop rotator cuff repr	15.44	NA	NA	9.67	10.16	2.67	090
29828		Α	Arthroscopy biceps tenodesis	13.00	NA	NA	8.46	8.46	2.17	090
29830		Α	Elbow arthroscopy	5.80	NA	NA	4.59	4.79	0.99	090
29834		Α	Elbow arthroscopy/surgery	6.33	NA	NA	4.99	5.21	1.08	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	NA	5.09	5.30	1.13	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	NA	5.77	6.04	1.22	090
29837		Α	Elbow arthroscopy/surgery	6.92	NA	NA	5.25	5.48	1.19	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	NA	5.82	6.11	1.30	090
29840		A	Wrist arthroscopy	5.59	NA	NA	4.71	4.88	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	NA	5.01	5.18	0.92	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	NA	4.98	5.20	1.04	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	NA	5.58	5.82	0.99	090
29846		Ą	Wrist arthroscopy/surgery	6.80	NA	NA	5.22	5.44	1.07	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	NA	5.38	5.60	1.08	090
29848		A	Wrist endoscopy/surgery	6.24	NA	NA	5.37	5.44	0.86	090
29850		A	Knee arthroscopy/surgery	8.18	NA	NA	5.30	5.24	1.25	090
29851		A	Knee arthroscopy/surgery	13.08	NA	NA	8.51	8.85	2.35	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	NA	7.51	7.84	1.85	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	NA	9.03	9.46	2.40	090
29860		A	Hip arthroscopy, dx	8.85	NA	ÑΑ	6.24	6.44	1.36	090
29861		A	Hip arthroscopy/surgery	9.95	NA	NA	6.81	6.96	1.59	090
29862		A	Hip arthroscopy/surgery	10.97	NA	NA	7.82	8.02	1.62	090
29863		A	Hip arthroscopy/surgery	10.97	NA	NA	7.72	7.94	1.42	090
29866		Α	Autgrft implnt, knee w/scope	14.48	NA	NA	9.65	10.10	2.40	090

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<sup>2</sup> If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

СРТЧ				Physi- cian Work	Fully Imple- mented Non- Facility PE	Year 2009 Transi- tional Non- Facility PE	Fully Imple- mented Facility PE	Year 2009 Transi- tional Facility PE	Mai- Practice	
<b>HCPCS</b>	Mod	Status	Description	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	RVUs <sup>2</sup>	Global
99060		В	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		В	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		В	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		В	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		В	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		В	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		В	Collect/review data from pt	1.10	0.37	0.37	ŇΑ	NA	0.04	XXX
99100		В	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		В	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	Z22
99135		В	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		В	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		С	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		С	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		$\epsilon$	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		С	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		С	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		Α	Anogenital exam, child	1,75	2.21	2.11	0.85	0.78	0.08	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.06	0.06	NΑ	NA	10.0	XXX
99174		N	Ocular photoscreening	0.00	0.69	0.69	NA	NA	0.01	XXX
99175		Α	Induction of vomiting	0.00	0.36	0.62	NA	NA.	0.10	XXX
99183		Α	Hyperbaric oxygen therapy	2.34	2.58	2.75	0.61	0.64	0.16	XXX
99185		Α	Regional hypothermia	0.00	1.81	1.52	NA	NA	0.04	XXX
99186		A	Total body hypothermia	0.00	1.63	1.67	NA	NA	0.45	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		Α	Phlebotomy	0.00	2.42	1.93	NA.	NA.	0.02	XXX
99199		С	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		Α	Office/outpatient visit, new	0.45	0.55	0.54	0.17	0.17	0.03	XXX
99202		A	Office/outpatient visit, new	0.88	0.85	0.83	0.32	0.32	0.05	XXX
99203		A	Office/outpatient visit, new	1.34	1.12	1.12	0.45	0.46	0.09	XXX
99204		A	Office/outpatient visit, new	2.30	1.51	1.51	0.75	0.74	0.12	XXX
99205		A	Office/outpatient visit, new	3.00	1.81	1.81	0.96	0.96	0.15	XXX
99211		A	Office/outpatient visit, est	0.17	0.32	0.34	0.06	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.45	0.55	0.55	0.16	0.16	0.03	XXX
99213		Ą	Office/outpatient visit, est	0.92	0.77	0.75	0.30	0.29	0.03	XXX
99214		A	Office/outpatient visit, est	1.42	1.10	1.09	0.46	0.45	0.05	XXX
99215		A	Office/outpatient visit, est	2.00	1.40	1.38	0.65	0.65	0.08	XXX
99217		A	Observation care discharge	1.28	NA NA	NA	0.50	0.51	0.06	XXX
99218		A	Observation care	1.28	NA	NA	0.39	0.40	0.06	XXX
99219		A	Observation care	2.14	NA	NA	0.62	0.64	0.10	XXX
99220		A	Observation care	2.99	NA	NA	0.86	0.91	0.14	XXX
99221		A	Initial hospital care	1.88	NA	NA	0.56	0.54	0.07	XXX
99222		A	Initial hospital care	2.56	NA	NA	0.74	0.74	0.10	XXX

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<sup>2</sup> If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

### **Attachment 3**

Summary of Comments Received

Comments Received

Transcript of Public Hearing

	Comments	Recommendations		
South Carolina Medical Association Todd Atwater, CEO, June 23, 2009				
	Workers' compensation system demands more from physicians.	Recommend rate increase for physician payment.		
	Outdated codes and in some cases no codes since 2003.	Establish task force, including physician members of SCMA, for the purpose of updating the manual.		
	Fees have not changed since 2003.	Set fees that includes cost of living increases to account for the cost of doing business relative to 2003.		
	Static reimbursement yet increasing costs of running a business.	Have an annual cost of living assessment.		
•	Georgia and NC have updated their provider manual on an annual basis and both states make the manual available online.	Make the manual available online.		
South Carolina Medical Association Will Floyd, MD, MPH, Chair, Occupational Medicine Committee, August 19, 2009				
	Supports using codes maintained by the American Medical Association.	Use a national average payment system of Medicare based on a multiple of 170%.		
	The current fee for medical testimony is not adequate because of administrative burdens and lost compensation due to the amount of time the physician spends away from schedule patients.	Have automatic annual payment updates that adjust for inflation.		
		Be able to access the manual online		
		Increase fees for CPT codes 99455 and 99456 to adjust for inflation.		
		Increase the fee for CPT code 99456 to \$800.		
		Suggests a tiered system of fees for IME to allow for extenuating circumstances.		
		Increase fees for medical testimony. Do not have sufficient data to recommend an appropriate fee.		
		Suggests that there be no differentiation between payment for testimony at a hearing or at a deposition.		

	Comments	Recommendations
South Carolina Orthopaedic Association J. Scott Broderick, MD, President June 24, 2009		
	Timely access to specialty care is critical and delays lead to higher costs.	Establish task force, including members of SCOA and SCMA, for the purpose of updating the manual.
	Orthopaedic surgeons understand their role to expedite scheduling, therapy, diagnostic studies and treatment which comes at a cost.	Increase fees to account for cost of living increases since 2003.
	Additional work demands that fees paid are adequate and revised frequently	Implement an annual cost of living increase for each code.
	Physician offices are small business not immune to pressures of escalating overhead.	Make the manual available online.
	Static or decreased revenue and increased expenses are not sustainable.	
South Carolina Orthopaedic Association Fraser Cobbe, Executive Director August 21, 2009		
August 21, 2000	•	Codes 99455 and 99456 be adjusted for inflation to \$114.17 and \$433.14. CPI has increased 17.7% since 2003.
		CPT Code 99456 would still be undervalued.
		Additional compensation should be provided for exceptional situations.
		American Academy of Orthopaedic Surgeons advisory statement on the appropriate considerations when determining compensation for medical testimony when the rate is not established by a third party or government program "Compensation for an orthopaedic expert will shall be reasonable and commensurate with expertise and the time and effort necessary to evaluate and testify on the facts of the case." Fee should equal amount earned if surgeon saw patients

equal amount earned if surgeon saw patients in the office or performed surgery. SCOA feels that \$1,000 would be adequate.

	Comments	Recommendations			
South Carolina Orthopaedic Association Steven C. Poletti, MD, President August 20, 2009					
	For those situations where an IME is significantly extended, a charge beyond \$800 would be justifiable.	In those cases, it should be up to the physician to justify such a charge and for the commissioner to approve the additional amount.			
		Manual be made available on line.			
		If the fees are to be based on Medicare, it should be 1.7 times the Medicare rate.			
		Recommends annual cost of living increases.			
		Recommends fees be either the "floor" for reimbursement, or the actual amounts reimbursed, not the "maximum allowable".			
Pee Dee Orthopaedic Associates Geoff McLeod, Practice Administrator June 22, 2009					
	There has been no fee increase since 2003.	Update CPT codes.			
	Physician expenses have risen considerably.	Post the manual, free of charge, on the internet			
	Administrative aspect of treating workers' compensation patients is vastly more complex, requiring practices to develop separate methods for dealing with workers' compensation patients.	Increase the conversion factor.			
	PDOA's cost for three workers' compensation specialists to handle claims is \$150,000 annually.				
	PDOA is a 10 physician practice which uses an electronic medical record system that costs more than \$400,000.				
	Studies have shown that an early referral to surgical specialists has numerous benefits.				
Lowcountry Orthopaedics & Sports Medicine, Carl H. Butler, Jr., CEO June 29, 2009	Madraral componenties is 270/ of sanding	Establish took fares in studios we sale			
	Workers' compensation is 27% of practice.	Establish task force, including members of SCOA and SCMA, for the purpose of updating the manual.			

	Comments	Recommendations			
	Employs 3 full time employees to meet the needs of the wc system.	Increase fees to account for cost of living increases since 2003.			
		Implement an annual cost of living increase for each code.			
		Make the manual available online.			
South Carolina Hospital Association Thomas D. Cockrell, Senior Vice President and COO, June 30, 2009					
and oco, cane oo, 2000	Workers' compensation cases are more complex than other cases and administrative simplification should be a major consideration	Reimbursement level should be set at a multiple of Medicare in the range of 160% to 180%.			
		If the reimbursement base is to be Medicare, there needs to be assurance that variation to the Medicare fee schedule is minimal.			
		If the Medicare fee schedule is to be the basis, processes need to be in place to provide for changes to the overall methodology structure as Medicare makes changes.			
		Processes need to be in place that would trigger automatic fee schedule adjustments for inflation.			
South Carolina Small Business Chamber of Commerce, Frank Knapp, Jr., President &					
CEO, August 20, 2009	Controlling costs is vital to the system however medical provders are also vital to the system and part of the small business community. These providers should be compensated fairly.				
	Matter of what is fair compensation through a medical fee schedule we will trust to the Commission's judgment.				
	With regard to IME, there apppears to be some concern that the Commission's guidelines are not being applied equally and might need to be changed.				

#### Comments

#### Recommendations

Asks if the IME fee schedule being observed and monitored by the Commission for both the insurance carrier and the plaintiff.

Questions the purpose of the IME fee schedule for the plaintiff if those medical fees are paid by the plaintiff, are not a component of the insurance carrier costs and thus cannot increase the cost of workers' compensation premiums.

Asks if the IME fees for the plaintiff increasing the system's cost to the business community. If not, why are these small business medical providers having their fees restricted?

#### South Carolina Society of Anesthesiologists, June 8, 2009

Lack of parity. Payment for anesthesia services are lowest of all physicians.

Medicare should not be used as a benchmark.

Medicare in South Carolina is particularly out of parity and the workers' compensation methodology exacerbates the problem.

The workers' compensation rate for anesthesiologists is lower than the State Health Plan.

The workers compensation system is slow to pay.

South Carolina workers' compensation payments are the lowest in the Southeast.

South Carolina is out of compliance with HIPAA regulations.

Since 2003 every payer has increased the anesthesia unit rate except workers' compensation.

Increase the unit rate to \$50.

Split MD/nurse payment to 60/40.

Comply with HIPAA regulations.

Address late and slow payments.

Comments Recommendations

Greenville Anasthesiology PA Robert R

Greenville Anesthesiology, PA Robert R. Morgan, Jr., MD, Past President, SCSOA, June 10, 2009

\$24/unit undervalues anesthesiologists services.

Rate is significantly less than every other Southeastern state.

Medicare rates arbitrarily devalue their services relative to other physicians.

Workers' compensation rates are less than half of the State Health Plan.

Reimbursement rates have languished for many years.



South Carolina Medical Association

Gregory Tarasidis, MD President-Elect

Marshall L. Meadors, III, MD Secretary

Dale R. Gordineer, MD Treasurer

Gary A. Delaney, MD Chairman of the Board

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John G. Black, MD

June 23, 2009

Medical Services Division South Carolina Workers' Compensation Commission Post Office Box 1715 Columbia, South Carolina 29202-1715

**RE: Public Comment on Physician Rates** 

#### To Whom It May Concern:

In light of the SC Workers Compensation Commission's (SCWCC) request for public comment on physician rate updates, please accept this communication as the South Carolina Medical Association's (SCMA) formal comments in response to this request. The SCMA applauds the SCWCC for its review and revision of these rates and the Provider Manual at this time and greatly appreciates the opportunity to participate in the process.

The SCMA represents over 6500 physicians in South Carolina. Our association is diverse in geographic location, age, gender, ethnicity and specialty. Many of our members treat workers compensation claimants in their practices and have done so in recent years at a cost to themselves. While the medical community recognizes the economic downturn in which we currently find ourselves, it is the SCMA's position that the SCWCC incorporate in its forthcoming recommendation *a rate increase* for physician payment.

In addition to making the best medical decisions and giving quality medical treatment, which is the extent of what is needed to treat patients with Medicare or private insurance, the workers' compensation system demands so much more from participating physicians. For example, dealing with attorneys, insurance carrier's agents, return to work issues including appropriate modified duty, providing fitness for duty evaluations, completing short and long term disability paperwork, determining impairment ratings, sitting for legal depositions, trying to meet employer's expectations, in addition to providing quality care for the patient, is what makes providing workers' compensation care so much more difficult and expensive.

At the same time, physicians have been functioning in our system with outdated codes and in some cases no codes since 2003, as well as a fee schedule which has not been

upgraded in nearly seven years. The same fee paid to repair a tibia fracture in 2003 is the same a surgeon can expect to receive in 2009. We have significant concerns with this trend of static reimbursement when faced with the increased costs of running a business. Seven years with no adjustments for the rising cost of doing business as a physician, which includes cost of living increases that we must provide for our nurses and staff, increased cost of supplies, higher malpractice rates and other overhead required to simply operate a medical practice is too long.

Our two closest neighbors - Georgia and North Carolina - have updated their provider manuals on an annual basis. Also, in both of these states, the manual is available online which makes it is easily accessible to the physician user and allows for updates to the various codes to conform to changes that are made in coding nationwide.

The recommendation of the SCMA is that the *South Carolina Workers' Compensation Providers' Manual* be updated from its current 2003 form. Specifically, we recommend:

- 1) A task force of stakeholders be assembled, including physician members of the SCMA, for the sole purpose of updating this manual;
- 2) Have a fee schedule for physicians that includes cost of living increases for each of the various codes to account for such growth, and the cost of doing business, relative to the 2003 values;
- 3) Have a built in annual cost of living assessment;
- 4) Make the manual available online such that it is easily accessible for the physician user. This will also allow for fees and codes to be easily updated as needed and allow for corrections to be easily made to the manual, if necessary.

While the Commission's responsibility to its constituents is to serve employers and workers in the most fair, responsive, and timely manner possible, it cannot be accomplished without dedicated physicians working hard to aggressively treat injured workers in an attempt to minimize permanent impairment and disability, which are the real cost drivers in the workers' compensation system.

We commonly share the goal of achieving a system that is efficient, effective and returns injured employees to work as soon as possible; therefore, we must subsequently have adequate resources to ensure a patient's access to care. If injured workers cannot receive treatment in a timely manner, the entire system collapses.

On behalf of the South Carolina Medical Association, I thank you for your time, attention and consideration of these important recommendations. If any additional information is needed or you would like to discuss this matter further, please do not hesitate to contact me at 803-798-6207.

Sincerely,

Todd K. Atwater

CEO



John G. Black, MD President

South Carolina Medical Association

Voice of One, Power of Many.

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Dela R. Card

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August 19, 2009

Medical Services Division South Carolina Workers' Compensation Commission Post Office Box 1715 Columbia, South Carolina 29202-1715 NR 24 09

RE: Response to CPT Code Inquiry - Medical Services Provider Manual Update

Dear Mr. Cannon:

Thank you for the opportunity to offer insight as the Workers Compensation Commission (WCC) continues its discussions regarding the revision of the Medical Services Provider Manual. The South Carolina Medical Association (SCMA) and its members greatly appreciate the chance to provide any helpful input during this process.

In your letter to SCMA CEO, Todd Atwater, dated July 30, 2009, you specifically request comment on CPT codes 99455 and 99456 – medical disability evaluation performed by a treating physician and a non-treating physician, respectively. As well as insight on 99075 and 99076 - medical testimony in a case hearing, and medical testimony in a deposition.

As chair of the SCMA's Occupational Medicine Committee, the above requests have been vetted by the Committee members and we respectfully make the following recommendations to the WCC on behalf of the SCMA:

- 1. In regards to updating the Provider Manual, our general comments are:
  - a. Full support of all relevant codes adopted and maintained by the American Medical Association (AMA);
  - b. Use of the national average payment system of Medicare based on a multiple of 170 percent;
  - c. Automated annual payment updates that adjust for inflation, and;
  - d. The ability to access the manual online to make it more accessible to the physician user as well as allowing for periodic updates to conform to changes that are made in coding nationwide.
- 2. In regards to codes 99455 and 99456, we propose:
  - a. Increasing the fees to adjust for inflation;
  - b. Due to the complexity and time-consuming nature of 99456 (medical disability evaluation performed by other than the treating physician), we feel increasing the current fee to \$800 would be reasonable;

- c. Additionally, we also suggest establishing a tiered system of payment based on extenuating circumstances encountered during such evaluations where the physician is required to perform exceptional duties that would merit additional compensation. We would fully expect and encourage justification and stringent guidelines for these circumstances to be substantiated prior to agreement of payment.
- 3. Likewise, your request concerning the fees pertaining to medical testimony in both a hearing and a deposition were discussed and we respectfully suggest the following:
  - a. An increase to the current fee payments rendered for these codes as set by the Commission; however, at this time the Occupational Medicine Committee given the deadline does not feel we have sufficient data to recommend an appropriate fee for these codes. We would welcome the opportunity to look into appropriate compensation in further detail before recommending a set fee amount.

We do, however, feel strongly that reimbursement for these services is *not* currently adequate for the following reasons:

- i. Administrative burdens placed on physician and staff in order to properly prepare for testimony, including case review for both trial *and* deposition, as well as additional responsibilities upon office staff due to the absence of the physician.
- ii. Lost compensation due to the amount of time the physician spends away from scheduled patients in his/her practice providing testimony.

The overriding justification in requesting additional compensation for these duties is clearly based on the recognition that a physician providing medical testimony in either a trial or deposition removes them from being able to treat their patients, directly impacting income, as well as the cost for continuing to maintain a viable practice, such as the cost for staff and overhead expenses while providing testimony. As a result, we suggest there be no differentiation between compensation for testimony at a trial or in a deposition as they both require similar preparation and they both remove the ability of the physician to continue to render services while providing testimony.

On behalf of the SCMA's Occupational Medicine Committee, I again thank you for your time and consideration of these important recommendations, especially given the complexity of these particular cases. If any additional information is needed or you would like to discuss this matter further, please do not hesitate to contact me at (803) 296-3304.

Sincerely,

Will Floyd MD, MPH

Chair, Occupational Medicine Committee



## South Carolina Orthopædic Association

Founded 1950

June 24, 2009

J. Scott Broderick, MD President

Steven C. Poletti, MD

President-Elect

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> Fraser Cobbe Executive Director

Medical Services Division South Carolina Workers' Compensation Commission P.O. Box 1715 Columbia, SC 29202-1715

Dear Commissioners,

Thank you very much for this opportunity to comment on the revision of the Medical Services Provider Manual. Orthopaedic Surgeons play a vital role in the Workers Compensation system. Whether it is by covering the local emergency room to scheduling outpatient treatment in their offices, orthopaedic surgeons are on the front lines in keeping our work force on the job. We appreciate the work of the Commission in administering an effective and efficient Compensation system.

The Workers Compensation system needs to be as self-executing as possible for it to meet its goals. Timely access to specialty care is critical for returning injured employees to work as soon as possible. Delays in treatment aggravate injuries and lead to higher costs to the system. We have attached a study that was referenced in our testimony in the Open Hearing that illustrates the benefits that timely access to specialty care can have on medical systems.

As orthopaedic surgeons we understand our role in the Workers Compensation system. We need to be prepared to expedite scheduling, therapy, diagnostic studies, and treatment for injured workers focusing on a rapid return to work. This involves working closely with patients and their representatives and case managers and adjusters representing the employer if we are going to navigate the system as efficiently as possible. Performance of this role comes at a cost to our practices as we allocate sufficient resources to handle the additional work required by the system.

This additional work demands that the fees paid to physicians are adequate and revised frequently. Our fee schedule in South Carolina has not changed since 2003. Physician offices are small businesses and are not immune to the pressures of escalating overhead. The model of static or decreased revenue and increased expenses simply is not sustainable over time. We recognize static reimbursement is not just a workers compensation issue but for the system to be efficient in

returning injured employees to work we must have adequate resources to ensure timely access to care.

As the Commission deliberates over the Medical Services Provider Manual, we stand with the South Carolina Medical Association (SCMA) and respectively request that you consider the following revisions:

- 1) A task force of stakeholders be assembled, including members of the South Carolina Orthopaedic Association and the SCMA, for the sole purpose of updating this manual;
- 2) Increase the fee schedule for physicians that amounts to a cost of living increase for each of the various codes relative to the 2003 values;
- 3) Implement an annual cost of living increase for each code;
- 4) Have the manual be made available online and easily accessible for the physician user. This will also allow for fees and codes to be easily updated as needed and allow for corrections to be easily made to the manual if necessary.

Thank you again for this opportunity to share our recommendations on revisions to the Medical Services Provider Manual. We stand ready to serve as a resource as the Commission deliberates.

We look forward to working with the Commission to ensure our Workers Compensation system operates in an efficient manner with the singular focus of returning injured workers to productivity as soon as possible.

Sincerely,

J. Scott Broderick, M.D.

Moderal

President

## Costs Analysis of Successful Rotator Cuff Repair Surgery: An Outcome Study. Comparison of Gatekeeper System in Surgical Patients

F. H. Savoie III, M.D., Larry D. Field, M.D., and R. Nan Jenkins, R.N.F.A.

Summary: In an effort to determine the cost effectiveness of rotator cuff repair surgery in workers' compensation patients, a financial analysis of 50 consecutive patients with a "successful" result was performed. Treatment costs were analyzed from the date of initial injury through all evaluations, diagnostic studies, surgical reconstruction, physical therapy and work hardening. Additionally, all workers' compensation payments and the cost of settlement was analyzed. The average cost of medical care was \$50,302.25 per patient. The average time to return to unrestricted duty from the date of injury was 11 months. However, patients referred to a specialist immediately following the diagnosis of a rotator cuff tear had total costs that averaged \$25,870.64 and returned to work an average of 7 months postoperatively. Patients managed via a "gatekeeper" system averaged \$100,280.10 in total costs and the average return to work was 18 months. These differences in cost and return to work were both statistically significant, P < .05. In conclusion, immediate referral of rotator cuff tears for specialized care results in decreased cost and earlier return to work. Key Words: Rotator cuff-Workers' Compensation—Gatekeeper.

The Workers' Compensation system was designed to provide medical coverage for job-related injuries. Ideally, this system provides quality medical care and support for the worker during convalescence, allowing a rapid return to work at a reasonable cost. Unfortunately, in many cases the system fails, resulting in exorbitant costs and patients unable or unwilling to work. We have postulated that even a successful result may be more costly in a Workers' Compensation case.

The purpose of this study is to determine the actual cost of successfully returning an injured patient to work. A secondary factor we analyzed was the effect

of a company physician "gatekeeper" in the management of these patients. To evaluate this hypothesis, we reviewed the financial records of 50 consecutive patients with full-thickness tears of the rotator cuff who returned to work in their previous occupation.

#### MATERIALS AND METHODS

Fifty consecutive patients with full-thickness tears of the rotator cuff who returned to normal work activities were evaluated for total medical costs, Workers' Compensation support pay while off work, and settlement costs. Ancillary costs (e.g., legal costs, replacement worker) were not included.

As we evaluated the cost to the Workers' Compensation system, it became apparent there were two separate groups of patients based on the type of medical care they received following the diagnosis of rotator cuff tear. Therefore, we analyzed these two groups

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separately in addition to the overall patient cohort. Group I patients (n=34) were managed by early referral to an orthopaedic specialist via the company physician. Group II patients (n=16) were managed by a "gatekeeper" type system in which the company physician was encouraged to keep medical care and decision making in house and refer to a specialist only as a last resort and only after he personally ordered and interpreted the various tests.

In 43 of the 50 patients, we were able to obtain all medical and Workers' Compensation costs. Seven patients (5 in group I, 2 in group II) refused to allow one or more parts of their financial data to be included in the study and were eliminated from the results.

## RESULTS

The average total cost per patient was \$50,302.25 (range, \$11,699 to \$462,964) in actual expenses (Table 1). The average medical cost was \$20,683.50 (range, \$9,526 to \$75,283). The average support pay and settlement cost was \$29,618.75 (range, \$1,384 to \$426,880).

Group I patients (Table 2) averaged \$25,870.64 in actual total expenditures whereas group II patients (Table 3) averaged \$100,910.60 in actual total expenditures.

In evaluating the time to return to full duty, the overall patient group returned an average of 10 months after injury (Table 1). Group I patients (Table 2) returned to work an average of 6.6 months after the injury; group II patients (Table 3) required 18 months to return to full duty.

Groups I and II were compared statistically for medical costs, Workers' Compensation cost, total cost, time from injury to surgery, and time off work. In each case, there was a statistically significant difference shown between the two groups using the *t*-test method in each comparison.

The mean cost of medical care among group I patients was \$13,513 with a standard deviation of \$3,817. The mean cost in group II was \$35,537 with a standard deviation of \$17,947. These differences in medical costs were statistically significant (P < .001).

The two groups were also compared in terms of the amount of Workers' Compensation payment (off work support pay plus settlement cost). In group I, the mean payment by the Workers' Compensation system was \$12,358 with a standard deviation of \$8,595. In group II, the mean cost was \$65,373 with a standard deviation

of \$104,974. These differences were statistically significant (P < .01).

The two groups were then compared for the total cost combining medical and workers' compensation costs to the system. Group I patients had a mean total cost of \$25,871 with a standard deviation of \$10,007. Group II patients had a mean cost of \$100,911 with a standard deviation of \$107,811. These differences in total cost were statistically significant (P < .001).

The time variable from the injury to the surgery was also compared in the two groups. Group I patients underwent surgical reconstruction of their shoulders at a mean time of 3.9 months after injury with a standard deviation of 3.2 months. Group II patients underwent surgical reconstruction of their shoulder at a mean time of 10.1 months after injury with a standard deviation of 4.4 months. These differences are also statistically significant (P < .001). The amount of time required for the patient to return to work was also compared between the two groups. Group I patients returned to work after a mean of 6.6 months with a standard deviation of 4.4 months. Group II patients remained off work for a mean of 17.1 months with a standard deviation of 9.2 months. This return to work difference was statistically significant (P < .001).

In each category compared, the group I patients managed by early referral had statistically significant lower costs, less time off work, and more rapid return to function than patients in group  $\Pi$ .

## DISCUSSION

The Workers' Compensation system was originally designed to care for workers' with injuries directly related to their occupation. Unfortunately, the system has deteriorated to cover all types of problems that may or may not be related directly to the occupation of the worker. This study is not designed to evaluate this area of the system. However, once a claim is made and verified, it is often difficult to return the patient to work. The reasons for this are multifactorial including the physical limitations of the injury, the ergonometric requirements of the job, psychological factors related to job satisfaction and environment, and social factors (i.e., receiving pay for not working).

It has been well established that the longer a patient remains off work and the more surgery the patient has received, the less likely the patient will return to work.<sup>3-5</sup> This would seem to indicate that the more quickly the injured patient receives definitive care the less the cost to the patient and the system. However,

TABLE 1. Groups I and II

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Worl
СВ	\$11,626.96	\$9,200.00	\$20,826.96	1	2	5
EB	9,789.89	3,657.21	13,447.10	1	1	7
CHB	11,220.00	10,467.00	21,687.00	1	1	4
RC ·	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	1	2	8 2
GF	12.801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	i	3	1
YZH	15,727.26	18,171.97	33,899.23	1	11	22 13
DH	14,781,47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	ĺ	10	11
JH ·	14,029.28	17,006.40	31,035.68	ī	4	7
IJ	19,207.80	19,370.75	38,578.55	ī	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6.
CL	9,674.94	10,178.60	19,853,54	i	6	2
ML	27,451.40	18,740.00	46,191.40	í	ĺ	7
ML BM	9,526.94	8,674.00	18,200.94	í	i	3
	15,288.00	10,522.30	25,810.30	î	3	7
WN		384.76	11,669.76	Ī	i	i
EP .	11,285.00	47,935.00	59,972.00	1		9
SC	12,037.00	18,333.00	31,230.00	Ī	2 3	5
RSM	12,897.00	74,656.00	149,939.70	2	19	23
ESM	75,283.70	11,500.00	22,995.58	1	2	4
T	11,495.00			1	I I	6
DTL	13,047.26	10,025.80	23,073.06	1		7
TR	11,784.50	10,634.74	22.419.24	•	3	6
T	10,977.50	10,832.00	21,809.50	1	I	10
řΤ	10,232.50	20,480.00	30,712.50	1	2	
T	20,413.26	5,695.33	26.108.59	1	11	4
W	14,621.67	19,946.66	34,568.33	l	9	10
W	12,079.86	7,040.00	19,119.86	1	. 9	3
В	24,661.85	50,428.00	75,089.85	2	4	19
C	33,460.52	18,337.04	51,797.56	2 2	7	16
C	20,017.20	31,418.19	51,435.39	2	14	1
H	13,418.28	7,528.39	20,946.67	1	4	5
H	36,084.97	426,880.00	462,964.97	2	7	19
L	32,256.73	27,620.59	59,877.32	2	14	28
VM	14,768.86	27,054.00	41,822.86	2 2 2	13	19
CP CP	51,254.00	28,802.76	80,056.76	2	14	37
P	27,431.14	31,088.40	58,519.54	2	4	10
'n	30,023.71	48,000.00	78.023.71	2	11	19
T	21,606.00	42,178.00	63,784.00	2	9	19
SP	32,344.57	41,628.12	73,972.69	2	8	4
ASM	28,157.00	28,200.00	56,357.00	2	12	10
w	70,174.30	38,932.78	109,107.08	2	6	16
OTA	20,683.50	29,618.75	50,302.26	0	5	10

NOTE. Cost is Medical Cost. Pay-sett is the sum of off work support pay and settlement cost. Tot-cost is the sum of medical costs, off work pay and settlement costs. Inj-Surg is the time from the reported injury until surgical reconstruction expressed in months. Off-work is the total time until the patient returned to unrestricted work.

there has recently been a movement to limit access to specialized care in an attempt to decrease medical costs. While in some instances limiting such access may be effective, the present study seems to show that limiting access actually results in increased costs.

The more quickly a rotator cuff injury is diagnosed and repaired the more quickly the patient should be able to return to useful employment.<sup>3,4</sup> This study strongly supports such a philosophy. In the present study, the sooner the patient underwent rotator cuff repair the sooner the patient was able to return to work.

The degree of difference in costs between the two groups was dramatic. Although it is difficult to extrapolate these data to other work related injuries, it is apparent that early referral of surgical rotator cuff injuries to a shoulder surgeon actually decreased costs significantly.

Care should be taken not to generalize the data presented in the present study as an indictment of the gatekeeper or company physician concept.

The gatekeeper may in fact have resulted in decreased costs if all patients presenting with shoulder complaints of any kind were included in this study.

TABLE 2. Group 1: Primary Referral Patients

Patients	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
СВ	\$11.626.96	\$9,200.00	\$20,826,96	ī	2	5
EB	9,789.89	3,657,21	13,447,10	í	ī	7
CHB	11,220.00	10,467.00	21,687.00	ī	í	Á
RC	15,715.94	7,966.30	23,682.24	Ī	3	8
DC	10,195.14	6,708.00	16,903.14	î	$\overset{\circ}{2}$	2
GF	12.801.84	11.240.39	24,042.23	î	6	4
EG	11,553.03	5,551.72	17,104.75	i	3	1
YZH	15,727.26	18,171.97	33,899,23	i	11	22
DH .	14,781.47	11.449.46	26,230.93	i	6	13
BH	17,040.50	12.832.00	29,872.50	i	10	11
JH	14,029.28	17.006.40	31.035.68	i	4	7
IJ	19,207.80	19,370.75	38.578.55	i	ī	13
BRJ	11,946.67	6,310.40	18.257.07	1	3	6
CL	9,674.94	10,178.60	19.853.54	î	6	2
VIL .	27,451.40	18,740.00	46.191.40	ī	1	7
3M	9.526.94	8,674.00	18.200.94	i	1	2
WN	15,288.00	10.522.30	25.810.30	i	3	7
EΡ	11,285.00	384.76	11,669.76	Í	1	í
SC	12,037.00	47,935.00	59,972.00	Î	2	9
RSM	12,897.00	18,333.00	31,230.00	î	2	5
T	11,495.00	11,500.00	22,995.58	í	2	
TL	13,047.26	10,025.80	23,073.06	i	1	6
TR	11,784.50	10,634.74	22,419.24	i	3	7
L	10.977.50	10,832.00	21,809,50	i	1	6
T	10,232.50	20,480.00	30,712,50	i	2	10
T	20,413.26	5,695.33	26,108.59	i	11	4
W	14,621.67	19,946.66	34,568.33	í	9	10
W	12,079.86	7,040.00	19,119.86	i	ģ	3
H	13,418.28	7,528.39	20,946.67	i	4	5
OTA	13.512.62	12,358.02	25,870.64	Ô	4	6

However, we were unable to find verifiable data supporting such a concept.

These patients had a specific surgical problem that required correction. This report does detail the benefits of early referral for specialty care when surgical intervention is warranted. In these patients who require a high level of

function from their shoulders, the delay in referral to a specialist, although well intentioned and often managed by excellent physicians, resulted in increased costs, as well as delays in return to work and functional activities.

Two conclusions can be drawn from this patient cohort: (1) A successful repair of the rotator cuff places

TABLE 3. Group II: "Gatekeeper" System Patients

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Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
PB	\$24,661.85	\$50,428.00	\$75,089,85	2	4	19
CC	33,460.52	18,337.04	51,797,56	$\bar{2}$	ż	16
EC	20,017.20	31,418,19	51,435,39	2	14	10
TH	36,084.97	426,880,00	462,964,97	2	7	19
RL	32,256.73	27.620.59	59,877,32	2	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JCP	51.254.00	28,802.76	80,056,76	2	14	37
CP	27,431.14	31.088.40	58,519,54	2	4	21
WR	30,023.71	48.000.00	78.023.71	2	17	19
JST	21,606.00	42,178.00	63,784.00	2	Q .	19
RSP	32,344,57	41,628,12	73,972.69	2	Ŕ	17
JASM	28,157.00	28.200.00	56,357.00	2	12	10
WW	70,174.30	38,932.78	109,107,08	2	6	16
JESM	75,283.70	74,656.00	149,939.70	2	19	23
TOTA	35,537.47	65,373.13	100,910.60	0	10	18

enormous costs on the Workers' Compensation system (average: \$50,302.25), and (2) delayed referral of rotator cuff tears to a specialist appears to result in increased costs (\$100,910.60  $\nu$  \$25,870.64) and delays in return to work (18 months  $\nu$  6 months).

Acknowledgment: The authors acknowledge the contribution of Dr. Ray Phelps (Millsaps College) for the statistical analysis.

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## **EHS**Today

## Access to Specialists May Reduce Workers' Compensation Costs

Aug 10, 2001 12:00 AM, By OH EDITORIAL STAFF

In contrast to managed care approaches, a program offering direct access to specialist doctors and increased physicians' fees may reduce workers' compensation costs, according to a study.

In contrast to managed care approaches, a program offering direct access to specialist doctors and increased physicians" fees may reduce workers" compensation costs, according to a study in the August Journal of Occupational and Environmental Medicine.

Dr. Stephen Atcheson of Reno, Nev., and colleagues evaluated a "specialist-direct" approach to workers" compensation cases from two large hotel-casinos.

In the new approach, workers with on-the-job injuries had direct access to physicians specializing in the care of musculoskeletal injuries.

Over two years, the program reduced overall workers" compensation costs by 63 percent.

Indemnity cost -- including compensation for missed work time and disability payments -- decreased by 85 percent.

Rapid access to specialists was a major factor in reducing indemnity costs, according to the study.

For minor injuries, the specialists were likely to recommend that the worker stay on the job with modified duties.

For more serious injuries, seeing a specialist early shortened the time until the patient received definitive care.

The specialist-direct approach also increased the fees paid to the primary care doctors treating the injured patients, but did not allow them to profit from "self-referral" for tests or treatments from which they might profit financially.

Under the new system, medical costs decreased by 45 percent -- even though the doctors received higher fees, the amount of services provided decreased.

Occupational injuries are an enormously expensive problem. In recent years, employers have considered managed care approaches, limiting limited access to specialists and discounted fees paid to physicians. However, these approaches have often failed to achieve expected cost reductions.

"Although more study of the specialist-direct approach is need, the preliminary results suggest it has the potential to achieve real cost reductions, rather than cost shifting, in the management of workers" compensation cases," said Atcheson.

by Virginia Foran

Acceptable Use Policy



## South Carolina Orthopædic Association

Founded 1950

August 21, 2009

Gary M. Cannon

Executive Director

State of South Carolina

1333 Main Street, Ste 500

Columbia, SC 29202-1715

Workers Compensation Commission

AUG 2 5 2009

8. C. WORKERS' COMP. COMM. EXECUTIVE DIRECTOR

J. Scott Broderick, MD President

Steven C. Poletti, MD President-Elect

Dear Mr. Cannon,

James A. O'Leary, MD Vice-President

Stephen Ridgeway, MD Secretary-Treasurer

Bernard G. Kirol, MD Immediate Past-President

Kyle J. Jeray, MD AAOS Board of Councilors

H. Del Schutte, Jr., MD

Fraser Cobbe Executive Director Thank you very much for the opportunity to provide input as the Workers Compensation Commission revises the Medical Service Provider Manual. Our organization sincerely appreciates the opportunity to submit comments.

Your letter dated July 30, 2009, specifically requested input on four codes or reimbursement policies currently under review. We have attempted to collect data and feedback from our members on these items while at the same time meeting your requested comment deadline of August 21st. This letter will provide our initial thoughts on these issues but we would be more than happy to work with the Commission and other interested medical associations and specialty societies to review each of these specific codes in a more in-depth fashion in the future.

AAOS Board of Councilors You have requested our thoughts on the appropriate reimbursement for codes 99455 (medical disability evaluation performed by the treating physician) and 99456 (medical disability evaluation performed by other than the treating physician). Our recommendation is that at a minimum both codes should be adjusted for inflation as they have remained static since 2003. According to our research the Consumer Price Index (CPI) for the South East Urban Areas of the United States has increased some 17.7% since 2003. We are happy to provide that documentation if requested. If we applied that inflation adjustment to the two codes in question the updated reimbursement would be \$114.17 for 99455 and \$433.14 for 99456.

> There was additional discussion among the membership that 99456 would still be undervalued at the current rate plus the requested CPI increase. The Commission may want to consider further elevating 99456 to recognize the significant work required in performing a disability evaluation by a non-treating physician.

In addition to the two codes referenced above, you had requested some feedback on exceptional instances where the physician is required to perform exceptional evaluations that would warrant additional compensation. We strongly believe that in some situations Workers Compensation cases can be extremely complex and do require exceptional evaluations and review. In those exceptional situations additional compensation should certainly be available.

Finally, you had requested our thoughts on fees for providing medical testimony at a hearing and medical testimony during a deposition. As noted in your letter those fees are currently established by the Commission and the rates are as follows:

Medical Testimony at a Hearing -  $99075 = $536 \ 1^{st}$  hour 99076 = \$134 each additional  $\frac{1}{4}$  hr

Medical Testimony in a Deposition - 99145 = \$320 1st hour 99145 = \$80 each additional 1/4 hr

The American Academy of Orthopaedic Surgeons has established an Advisory Statement to guide Orthopaedic Surgeons on the appropriate considerations when determining compensation for Medical Testimony when the rate is not established by a third party or governmental program. This Advisory Statement has been incorporated into the AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons. The Code specifically states the following:

"Compensation for an orthopaedic expert witness shall be reasonable and commensurate with expertise and the time and effort necessary to evaluate and testify on the facts of the case."

Furthermore the AAOS has published guidance on how surgeons can comply with this Code of Ethics when determining their fees for Medical Testimony. That guidance includes the following measurable methods:

- Fee equal to the amount earned if the orthopaedic surgeon saw patients in the office that day
- Fee equal to the amount earned if the orthopaedic surgeon performed surgery that day
- Fee equal to the amount earned through a combination of office and surgery work

The underlying premise of these standards for determining compensation is the recognition that providing medical testimony, both during a trial or for a deposition, removes the physician from the practice and eliminates their ability to treat patients and receive reimbursement for services rendered. It also recognizes the obligations for continuing to maintain a practice including staff and overhead expenses while providing testimony.

Our organization strongly believes the current reimbursement established by the Commission is not sufficient to adequately compensate physicians for providing Medical Testimony at a hearing or during a deposition. We feel adequate compensation would be \$1,000 for the first hour and \$250 for every additional quarter hour. Furthermore we do not believe there should be a differentiation between compensation for testimony at a trial or in a deposition as 1) they both require the physician similar preparation, case review, and evaluation and 2) they both remove the ability of the physician to continue to render services while providing testimony.

Again, thank you very much for the opportunity to comment on these specific items. We look forward to working with the Commission during this review of the Medical Services Provider Manual and achieving our mutual goal of ensuring the efficiency of the system and quality care for injured workers.

Sincerely,

Fraser Cobbe

**Executive Director** 

Cc: SCOA Executive Committee

# Databases, Tables & Calculators by Subject

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Change Output Options: From: 2003 To: 2009

8

include graphs **new!** 

More Formatting Options

Data extracted on: June 16, 2009 (1:09:09 PM)

Consumer Price Index - All Urban Consumers

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SPINAL SURCERY Donald R. Johnson, II, MD Steven C. Poletti, MD Thomas F. Roush, MD

Danny Butler, PA-C Justin Swain, PA-C Amanda Thurber, PA-C

CONSERVATIVE SPING CARE Leonard E. Forrest, MD John F. Johnson, MD G. Robert Richardson III, MD

PAIN MANAGEMENT Mark D. Netherton, MD Blane Richerdson, MD Vitginia Blease, PA-C Susanne Livengood, PA-C MAIN OFFICE 1106 Chuck Dawley Blod., Suite 200 Mt. Pleasant, SC 29464

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1941 Savage Rd., Stb. 1005 Charleston, SC 29407 (843) 763-2720

August 20, 2009

Mr. Gary Cannon
Executive Director
State of South Carolina
Workers' Compensation Commission
1333 Main Street, Suite 500
Columbia, SC 29202-1715

Dear Mr. Cannon:

This is an addendum to my letter to you dated 8/18/09.

After further review and discussion with members of the South Carolina Orthopaedic Association, and also discussion with others in the medical community, our recommendation for the fee for an independent medical examination is that it be \$800. There could be situations where such evaluations are significantly extended such that a charge beyond \$800 would be justifiable. However, in those cases it should then be up to the physician who performed the independent medical examination to justify such a charge to the commissioner who is hearing that particular case. The commissioner would then rule as to whether this additional amount was deserved or not.

With regard to the provider manual, our recommendation is that it be made available on line and updated as the AMA codes are updated. Further, it should include all available codes.

As for the fees for office visits and procedures, if it is to be based on Medicare, our recommendation is that the fee be 1.7 times the current Medicare rate. We also recommend a cost of living increase annually.

We are also recommending that the fees be either the "floor" for reimbursement, or the actual amounts reimbursed, and not "maximum allowable".

Thank you for your consideration.

Sincerely,

Steven C. Poletti, MD

President

South Carolina Orthopaedic Association

June 22, 2009

Medical Services Division South Carolina Workers' Compensation Commission Post Office Box 1715 Columbia, SC 29202-1715

Dear Sirs:

I write to you on behalf of Pee Dee Orthopaedic Associates, P.A. (PDOA) to indicate our concern regarding the current review of the Medical Services Provider Manual.

I would like to thank you for the opportunity to verbally present our position regarding the current review at the public hearing on June 19, 2009. I was very impressed with the manner in which the hearing was conducted, and the professionalism shown by commissioners that presided over the hearing.

The current South Carolina Medical Services Provider Manual has been in effect since 2003. Since 2003, the reimbursement for the services provided by physicians has seen no increase. During the same period, the expense to physicians for providing medical services has risen considerably. The administrative aspect of treating workers' compensation patients is vastly more complex than treating non workers' compensation patients. In order to deal with this complexity, medical practices are essentially required to develop a separate internal method for dealing with workers' compensation patients, each of which has its own unique issues.

In order to ensure that PDOA complies with all of the reporting requirements associated with workers' compensation patients, PDOA has three (3) employees, whose sole responsibility is dedicated workers' compensation patients. Two of the three employees are Workers' Compensation Specialists. The Workers' Compensation Specialists are responsible for triaging initial incoming phone calls, communicating information to patients, case managers, and employers. They also schedule Independent Medical Evaluations. PDOA also has an employee whose sole responsibility is to ensure that all workers' compensation claims are submitted properly to employers or insurance carriers. In total, salary and benefits for the three employees that deal solely with workers' compensation patients exceeds \$150,000 per year.

The administrative issues associated with workers' compensation patients are substantially more involved than with non workers' compensation patients. From the first interaction between

Pee Dee Orthopaedic Associates, P.A. 901 E. Cheves St., Suite 100 • Florence, SC 29506 1580 Freedom Blvd., Suite 100 • Florence, SC 29505 (843) 662-5233 • Fax (843) 678-9003 www.pdoa.com



MN 2 3 '09



PDOA and the employer/case manager until patient discharge, every step of the treatment process is more detailed and involved than non workers' compensation patients. The amount of information needed in order to schedule a workers' compensation patient is far greater than of a non workers' compensation patient. This involves obtaining permission to see and treat the patient, the information needed for input into our computer system, work restrictions, obtaining authorization for testing or surgical procedures, maximum improvement, and impairment ratings add to the difficulty of treating workers' compensation patients.

PDOA utilizes an electronic medical record (EMR) called ChartLogic. ChartLogic electronically stores patient demographic information and treatment records. While this eases record management, EMRs are extremely expensive. PDOA expenses for ChartLogic, including software, IT support, equipment, and training have exceeded \$400,000. PDOA is comprised of ten (10) physicians. For smaller practices, an EMR is simply not feasible, and therefore, the process of providing care to workers' compensation patients is made much more difficult.

We also urge the Commission to update the CPT codes in the manual and post the manual on the internet. Many of the CPT codes listed in the manual are outdated, and thus, denied by carriers. An updated manual would eliminate outdated codes, denials from carriers, and allow for instant access to coding updates. Posting the manual on the internet would also allow for instant access to updates, and give greater access to the manual for smaller providers.

Studies have shown that an early referral to surgical specialists has numerous benefits. In a retrospective study of complete rotator cuff tears by Dr. Savoie, et al, patients given a prompt referral to an orthopaedic surgeon returned to work in an average of 6.6 months, as opposed to 17.1 months for those that did not receive a prompt referral. Mean medical costs for those receiving an early referral to specialists was \$13,513, opposed to \$35,537 that did not. Mean workers' compensation payments (off work support pay plus settlement costs) were \$12, 358 for those receiving an early referral, as opposed to \$65,373 that did not. Mean total cost combining medical and workers' compensation costs were \$25,871 for those receiving an early referral to an orthopaedic surgeon, compared to \$100,007 that did not. Clearly, surgical specialist involvement saves the employer a considerable amount in wages, support payments, and an employees' time away from work. A copy of the article is enclosed for review.

In summary, we ask that the Commission increase the conversion factor for workers' compensation patients, update the CPT codes in the manual, and post the manual, free of charge, on the internet.

Geoff McLeod

Practice Administrator

Pee Dee Orthopaedic Associates

Geff Me Les

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## Costs Analysis of Successful Rotator Cuff Repair Surgery: An Outcome Study. Comparison of Gatekeeper System in Surgical Patients

F. H. Savoie III, M.D., Larry D. Field, M.D., and R. Nan Jenkins, R.N.F.A.

Summary: In an effort to determine the cost effectiveness of rotator cuff repair surgery in workers' compensation patients, a financial analysis of 50 consecutive patients with a "successful" result was performed. Treatment costs were analyzed from the date of initial injury through all evaluations, diagnostic studies, surgical reconstruction, physical therapy and work hardening. Additionally, all workers' compensation payments and the cost of settlement was analyzed. The average cost of medical care was \$50,302.25 per patient. The average time to return to unrestricted duty from the date of injury was 11 months. However, patients referred to a specialist immediately following the diagnosis of a rotator cuff tear had total costs that averaged \$25,870.64 and returned to work an average of 7 months postoperatively. Patients managed via a "gatekeeper" system averaged \$100,280.10 in total costs and the average return to work was 18 months. These differences in cost and return to work were both statistically significant, P < .05. In conclusion, immediate referral of rotator cuff tears for specialized care results in decreased cost and earlier return to work. Key Words: Rotator cuff---Workers' Compensation-Gatekeeper.

The Workers' Compensation system was designed to provide medical coverage for job-related injuries. Ideally, this system provides quality medical care and support for the worker during convalescence, allowing a rapid return to work at a reasonable cost. Unfortunately, in many cases the system fails, resulting in exorbitant costs and patients unable or unwilling to work. We have postulated that even a successful result may be more costly in a Workers' Compensation case.

The purpose of this study is to determine the actual cost of successfully returning an injured patient to work. A secondary factor we analyzed was the effect

of a company physician "gatekeeper" in the management of these patients. To evaluate this hypothesis, we reviewed the financial records of 50 consecutive patients with full-thickness tears of the rotator cuff who returned to work in their previous occupation.

## MATERIALS AND METHODS

Fifty consecutive patients with full-thickness tears of the rotator cuff who returned to normal work activities were evaluated for total medical costs, Workers' Compensation support pay while off work, and settlement costs. Ancillary costs (e.g., legal costs, replacement worker) were not included.

As we evaluated the cost to the Workers' Compensation system, it became apparent there were two separate groups of patients based on the type of medical care they received following the diagnosis of rotator cuff tear. Therefore, we analyzed these two groups

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separately in addition to the overall patient cohort. Group I patients (n = 34) were managed by early referral to an orthopaedic specialist via the company physician. Group II patients (n = 16) were managed by a "gatekeeper" type system in which the company physician was encouraged to keep medical care and decision making in house and refer to a specialist only as a last resort and only after he personally ordered and interpreted the various tests.

In 43 of the 50 patients, we were able to obtain all medical and Workers' Compensation costs. Seven patients (5 in group I, 2 in group II) refused to allow one or more parts of their financial data to be included in the study and were eliminated from the results.

## RESULTS

The average total cost per patient was \$50,302.25 (range, \$11,699 to \$462,964) in actual expenses (Table 1). The average medical cost was \$20,683.50 (range, \$9,526 to \$75,283). The average support pay and settlement cost was \$29,618.75 (range, \$1,384 to \$426,880).

Group I patients (Table 2) averaged \$25,870.64 in actual total expenditures whereas group II patients (Table 3) averaged \$100,910.60 in actual total expenditures.

In evaluating the time to return to full duty, the overall patient group returned an average of 10 months after injury (Table 1). Group I patients (Table 2) returned to work an average of 6.6 months after the injury; group II patients (Table 3) required 18 months to return to full duty.

Groups I and II were compared statistically for medical costs, Workers' Compensation cost, total cost, time from injury to surgery, and time off work. In each case, there was a statistically significant difference shown between the two groups using the *t*-test method in each comparison.

The mean cost of medical care among group I patients was \$13,513 with a standard deviation of \$3,817. The mean cost in group II was \$35,537 with a standard deviation of \$17,947. These differences in medical costs were statistically significant (P < .001).

The two groups were also compared in terms of the amount of Workers' Compensation payment (off work support pay plus settlement cost). In group I, the mean payment by the Workers' Compensation system was \$12,358 with a standard deviation of \$8,595. In group II, the mean cost was \$65,373 with a standard deviation

of \$104,974. These differences were statistically significant (P < .01).

The two groups were then compared for the total cost combining medical and workers' compensation costs to the system. Group I patients had a mean total cost of \$25,871 with a standard deviation of \$10,007. Group II patients had a mean cost of \$100,911 with a standard deviation of \$107,811. These differences in total cost were statistically significant (P < .001).

. The time variable from the injury to the surgery was also compared in the two groups. Group I patients underwent surgical reconstruction of their shoulders at a mean time of 3.9 months after injury with a standard deviation of 3.2 months. Group II patients underwent surgical reconstruction of their shoulder at a mean time of 10.1 months after injury with a standard deviation of 4.4 months. These differences are also statistically significant (P < .001). The amount of time required for the patient to return to work was also compared between the two groups. Group I patients returned to work after a mean of 6.6 months with a standard deviation of 4.4 months. Group II patients remained off work for a mean of 17.1 months with a standard deviation of 9.2 months. This return to work difference was statistically significant (P < .001).

In each category compared, the group I patients managed by early referral had statistically significant lower costs, less time off work, and more rapid return to function than patients in group II.

## DISCUSSION ·

The Workers' Compensation system was originally designed to care for workers' with injuries directly related to their occupation. Unfortunately, the system has deteriorated to cover all types of problems that may or may not be related directly to the occupation of the worker. This study is not designed to evaluate this area of the system. However, once a claim is made and verified, it is often difficult to return the patient to work. The reasons for this are multifactorial including the physical limitations of the injury, the ergonometric requirements of the job, psychological factors related to job satisfaction and environment, and social factors (i.e., receiving pay for not working).

It has been well established that the longer a patient remains off work and the more surgery the patient has received, the less likely the patient will return to work.<sup>3-5</sup> This would seem to indicate that the more quickly the injured patient receives definitive care the less the cost to the patient and the system. However,

TABLE 1. Groups I and II

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
СВ	\$11,626.96	\$9,200.00	\$20,826.96	I	2	5
EB	9,789.89	3,657.21	13,447.10	I	1 .	7
CHB	11,220.00	10,467.00	21,687.00	1	1	4
RC	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	I	2	2
GF	12,801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	1	3	1
YZH	15,727.26	18,171.97	33,899.23	1	11	22
DH	14,781.47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	1	10	11
JН	14,029.28	17,006.40	31,035.68	1	4	7
LJ	19,207.80	19,370.75	38,578.55	1	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6
CL	9,674.94	10,178.60	19,853.54	I	6	2
ML	27,451.40	18,740.00	46,191,40	1	1	7
BM	9,526,94	8.674.00	18,200.94	1	1	3
WN	15,288.00	10,522.30	25,810.30	1	3	7
EP	11,285.00	384.76	11,669.76	1	` 1	1
JSC	12,037.00	47,935.00	59,972.00	1	2	9
RSM	12,897.00	18,333.00	31,230.00	1	3	5
JESM	75,283.70	74,656.00	149,939.70	2	19	23
LT	11,495.00	11,500.00	22,995.58	1	2	4
DTL	13,047.26	10.025.80	23,073.06	1	1	. 6
DTR	11,784.50	10,634.74	22.419.24	ī	3 -	7
JT	10,977.50	10,832.00	21,809.50	ī	1	6
GT	10,232.50	20,480.00	30,712.50	· i	2	10
DT	20,413.26	5,695.33	26,108.59	î	11	4
DW	14,621.67	19,946.66	34,568.33	i i	9	10
vw	12,079.86	7,040.00	19,119.86	î	9	3
PB	24,661.85	50,428.00	75,089.85	$\hat{\mathbf{z}}$	4	19
CC	33,460.52	18,337.04	51,797.56	$\bar{2}$	ż	16
EC	20,017.20	31.418.19	51,435.39	$\tilde{\mathbf{z}}$	14	1
GH	13,418.28	7,528.39	20,946.67	ĩ	4	5
TH	36,084.97	426.880.00	462,964.97	2 .	7	19
RL	32,256.73	27,620.59	59,877.32	2 .	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JWM JCP	51,254.00	28,802.76	80,056.76	2	14	37
		31,088.40	58,519.54	2	4	10
CP	27,431.14 30,023.71	48,000.00	78,023.71	2 2	11	10
WR.			63,784.00	$\overset{2}{2}$	9	19
JST	21,606.00	42,178.00	73,972.69	2	8	4
RSP	32,344.57	41,628.12		2 2	12	10
CASM	28,157.00	28,200.00	56,357.00	4		16
WW	70,174.30	38,932.78	109,107.08	2	6 5	10
TOTA	20,683.50	29,618.75	50,302.26	0 -	<b>ɔ</b> ,	10

NOTE. Cost is Medical Cost. Pay-sett is the sum of off work support pay and settlement cost. Tot-cost is the sum of medical costs, off work pay and settlement costs. Inj-Surg is the time from the reported injury until surgical reconstruction expressed in months. Off-work is the total time until the patient returned to unrestricted work.

there has recently been a movement to limit access to specialized care in an attempt to decrease medical costs. While in some instances limiting such access may be effective, the present study seems to show that limiting access actually results in increased costs.

The more quickly a rotator cuff injury is diagnosed and repaired the more quickly the patient should be able to return to useful employment.<sup>3,4</sup> This study strongly supports such a philosophy. In the present study, the sooner the patient underwent rotator cuff repair the sooner the patient was able to return to work.

The degree of difference in costs between the two groups was dramatic. Although it is difficult to extrapolate these data to other work related injuries, it is apparent that early referral of surgical rotator cuff injuries to a shoulder surgeon actually decreased costs significantly.

Care should be taken not to generalize the data presented in the present study as an indictment of the gatekeeper or company physician concept.

The gatekeeper may in fact have resulted in decreased costs if all patients presenting with shoulder complaints of any kind were included in this study.

TABLE 2. Group I: Primary Referral Patients

Patients	Cost	Pay-Sett	·Tot-Cost	Group	Inj-Surg	Off-Work
СВ	\$11,626.96	\$9,200.00	\$20,826.96	1	2	5
EB	9,789.89	3,657.21	13,447.10	I	1	7
CHB	11,220.00	10,467.00	21,687.00	1	1	. 4
RC .	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	1	2	2
GF	12,801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	1	:3	1
YZH ·	15,727.26	18,171.97	33,899.23	1	11	22
DH	14,781.47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	1	10	11
JH	14,029.28	17,006.40	31,035.68	1	4	7
IJ	19,207.80	19.370.75	38,578.55	1	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6
CL	9,674.94	10,178.60	19,853.54	1	6	
ML	27,451.40	18,740.00	46,191.40	1	1	2 7
BM	9,526,94	8,674.00	18,200.94	1	1	3
WN	15,288.00	10,522.30	25,810.30	1	3	7
EP	11,285.00	384.76	11,669.76	1	1	1
JSC	12,037.00	47,935.00	59,972.00	ī	2	9
RSM	12,897.00	18,333.00	31,230.00	1	3	5
LT	11,495.00	11,500.00	22,995.58	1	2	4
DTL	13,047,26	10,025,80	23,073.06	<u></u>	ï	6
DTR	11,784.50	10,634,74	22,419.24	ï	3	7
JT	10,977.50	10.832.00	21,809.50	Ī	1	. 6
GT	10,232.50	20,480.00	30,712.50	1	2 .	10
DT	20,413.26	5,695.33	26,108.59	Ī	. 11	4
DW	14,621.67	19,946.66	34,568.33	1	9	10
VW	12,079.86	7,040.00	19,119.86	1	9	3
GH	13,418.28	7,528.39	20,946.67	1	4	5
TOTA	13,512.62	12,358.02	25,870.64	Ō	4	6

However, we were unable to find verifiable data supporting such a concept.

These patients had a specific surgical problem that required correction. This report does detail the benefits of early referral for specialty care when surgical intervention is warranted. In these patients who require a high level of

function from their shoulders, the delay in referral to a specialist, although well intentioned and often managed by excellent physicians, resulted in increased costs, as well as delays in return to work and functional activities.

Two conclusions can be drawn from this patient cohort: (1) A successful repair of the rotator cuff places

TABLE 3. Group II: "Gatekeeper" System Patients

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
PB	\$24,661.85	\$50,428.00	\$75,089.85	2	4	19
CC	33,460.52	18,337.04	51,797.56	2	7	16
EC	20,017.20	31,418.19	51,435.39	2	14	1
TH	36,084.97	426,880.00	462,964.97	2	7	19
RL	32,256.73	27,620.59	59,877.32	2	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JCP	51,254.00	28,802.76	80,056.76	2	14	37
CP	27,431.14	31,088.40	58,519.54	2	4	21
WR	30,023.71	48,000.00	78,023.71	2	11	19
JST	21,606.00	42,178.00	63,784.00	2	9	. 19
RSP	32,344.57	41,628.12	73,972.69	2	8	5
JASM	28,157.00	28,200.00	56,357.00	2	12	10
ww	70,174.30	38,932.78	109,107.08	2	6	16
JESM	75,283.70	74,656.00	149,939.70	2	. 19	23
TOTA	35,537.47	65,373.13	100.910.60	0	10	18

enormous costs on the Workers' Compensation system (average: \$50,302.25), and (2) delayed referral of rotator cuff tears to a specialist appears to result in increased costs (\$100,910.60  $\nu$  \$25,870.64) and delays in return to work (18 months  $\nu$  6 months).

Acknowledgment: The authors acknowledge the contribution of Dr. Ray Phelps (Millsaps College) for the statistical analysis.

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- Roper Hospital
- · Roper Berkeley Day Hospital
- Bon Secours St. Francis Hospital
- East Cooper Regional Medical Center
- Healthsouth Rehabilitation Hospital
- Charleston Surgery Center

June 29, 2009

Medical Services Division South Carolina Workers' Compensation Commission P.O. Box 1715 Columbia, SC 29202-1715

Dear Commissioners,

Thank you very much for this opportunity to comment on the revision of the Medical Services Provider Manual. Lowcountry Orthopaedics & Sports Medicine physicians and staff are heavily involved in caring for the Workers Compensation population. On average, about 27% of the patients we treat in our practice are Workers Compensation.

Our goal when treating Workers Compensation patients is to efficiently provide treatment for injured workers in an effort to allow them to return to work as soon as possible. This involves working closely with patients, their representatives, and/or case managers and adjusters. As mentioned in our testimony in the Open Hearing, we employ 3 full time employees whose sole job is to meet the needs of the Workers Compensation system and its paperwork, authorization, and communication demands. No other payor requires this level of resource.

As you know, the South Carolina fee schedule has not changed since 2003. It has maintained outdated codes and allowed fees to fall below what some private payors allow. As small businesses, we are subject to the pressures of escalating overhead and are forced to make business decisions on the types of payors we will accept, based on the fee schedule of the particular payor and the cost to treat patients. We are grateful to the Commission for its willingness to update the Medical Services Provider Manual, and would encourage the Commission to adopt strategies similar to Georgia and North Carolina to keep the fee schedule and codes updated on an annual basis. We stand with the South Carolina Medical Association (SCMA) and respectively request that you consider the following revisions:

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- A task force of stakeholders be assembled, including members of the South Carolina Orthopaedic Association and the SCMA, for the sole purpose of updating this manual;
- Increase the fee schedule for physicians that amounts to a cost of living increase for each of the various codes relative to the 2003 values;
- 3) Implement an annual cost of living increase for each code;
- 4) Have the manual be made available online and easily accessible for the physician user. This will also allow for fees and codes to be easily updated as needed and allow for corrections to be easily made to the manual if necessary.

Thank you again for this opportunity to share our recommendations on revisions to the Medical Services Provider Manual.

Sincerely,

Carl H. Butler, Jr.

Cal H. Butler, J.

**CEO** 

Joel R. Cox, Jr. MD James D. Spearman, MD Richard H. Zimlich, MD Shailesh M. Patel, MD Eric S. Stem, MD Amy M. Stanton, PA-C Cynthia H. Zeigler CFNP James J. McCoy, Jr., MD Don O. Stovall, Jr., MD David H. Jaskwhich, MD Chad R. Burgoyne, MD Jason K. Trigiani, PA-C Ashley L. Burleson, NP-C



1000 Center Point Road | Columbia, SC 29210-5802 | Ph. 803.796.3080 | www.scha.org

June 30, 2009

Medical Services Division South Carolina Workers' Compensation Commission Post Office Box 1715 Columbia, SC 29202-1715

On behalf of the more than 85 institutional and 600 personal members of the South Carolina Hospital Association, we are pleased to submit comments to the Commission regarding the *Medical Services Provider Manual*. At this point, without specific recommendations in which to respond, our general comments are as follows:

- 1. Administrative: Generally speaking, workers compensation cases are more complex than other cases and the administrative burden is much more significant. Administrative simplification for workers compensation cases should be a major consideration.
- 2. Reimbursement Base: Due to the complexity of the cases, and the aforementioned administrative burden, the basic reimbursement level (fee schedule) should be set at a multiple of Medicare in the range of 160% 180%.
- 3. Variations: If the reimbursement base is to be Medicare, there needs to be assurance that variations to the Medicare fee schedule is minimal if at all. Variations to the fee schedule add to the already complex administrative burdens for providers, payors and the Commission.
- 4. **Methodology Updates**: Again, if the Medicare fee schedule is to be the base, processes need to be in place to provide for changes to the overall methodology structure as Medicare makes changes.
- 5. Payment Updates: Processes need to be in place that would trigger automatic fee schedule adjustments for inflation.

The hospital and medical community appreciates the opportunity to serve South Carolina workers compensation patients but feel strongly about adequate reimbursement and the minimization of the administrative burdens.

Again, thank you for the opportunity to provide comments and please feel free to contact me should there be any questions.

Sincerely,

Thomas D. Cockrell, FHFMA Senior Vice President and COO

Journ Cochall



## The SC Small Business Chamber of Commerce

1717 Gervais Street, Columbia, SC 29201 (803) 252-5733 fax (803) 799-0678 www. scsbc.org

August 20, 2009

Gary M. Cannon
Executive Director
Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Dear Gary,

Thanks for your letter requesting our input into your revisions of the Medical Services Provider Manual. As you know, The S.C. Small Business Chamber of Commerce represents a wide variety of small businesses in the state. Many of our members carry workers' compensation insurance. We have worked very hard with our Legislature and Administrative Law Court to improve the workers' compensation laws, increase the resources of the Commission to more effectively carry out their mission and protect the business community from excessive rate increases.

The Medical Service Provider Manual, which establishes allowable medical fees, is of great interest to the Small Business Chamber to the degree that medical provider fees increase costs to the small business community through premiums. Controlling costs is vital to the system, however, medical providers are also vital to the system and part of the small business community. These providers should be compensated fairly for their services.

The matter of what is fair compensation through medical fee schedule we will trust to the Commission's judgment. However, in regard to the independent medical examination fee schedule, my understanding is that it is to apply equally to all parties in a workers' compensation case. In talking with others about our response to your letter, there appears to be some concern that the Commission's guidelines in this area are not being applied equally and might actually need to be changed.

First, is the independent medical examination fee schedule being observed and monitored by the Commission for both the insurance carrier and the plaintiff? The Commission should be able to guarantee that all parties are abiding by the current fee structure and requirements. This is especially true for the insurance carriers involved because it is their independent medical fee expenses that contribute directly to the cost of workers' compensation premiums. Allowing the insurance carriers to disregard the fee schedule has a direct negative impact on small businesses. Can you shed some light on this issue?

Second, what is the purpose of the independent medical examination fee schedule for the plaintiff if those medical fees are paid by the plaintiff, are not a component of the insurance carrier costs and thus cannot increase the cost of workers' compensation premiums? Are the

independent medical examination fees for the plaintiff increasing the system's cost to the business community? If not, why are these small business medical providers having their fees restricted for the plaintiff's independent medical examinations? Your opinion on this would be appreciated.

Thank you for the opportunity to have input into this process.

Sincerely,

Frank Knapp, Jr. President & CEO Anesthesia Services Rates in the Workers' Compensation Program

Presented by: South Carolina Society of Anesthesiologists June 8, 2009

## Anesthesiology and the S.C. Worker's Compensation Program

## <u>Issues</u>

- 1. Lack of Parity. Anesthesia services are reimbursed by the Worker's Comp Program at the lowest rate of all physician providers (as compared to % of charges and % of commercial rates).
- 2. Medicare Should Not be the Benchmark for Worker's Comp. The 1992 Medicare Fee Schedule arbitrarily reduced the anesthesiology conversion factor by 29% and again in 1998 the entire Medicare formula conversion was flawed with a resulting 54% reduction. Medicare rates are usually 71-80% of commercial rates across all specialties, except for anesthesiology, where it is only 30% of the commercial rate.
- 3. Medicare in South Carolina is particularly out of parity. The Medicare conversion factor for South Carolina is in the bottom 2% of the nearly 250 Medicare Conversion Factors for Anesthesia.
- 4. WC's Methodology Exacerbates the Problem. In 1998, the S.C.'s Worker's Comp Program changed its reimbursement methodology by instituting a 50/50 fee split between the anesthesiologist and the anesthesia nurse. Before 1998, the MD rate was twice that of the nurse rate. Not only does this devalue the role of the physician, but the actual reimbursement rate to the physician is \$12/unit and not the published \$24/unit, when the MD is supervising an anesthesia nurse.
- 5. WC is Lower than the State Health Plan. The S.C. State Health Plan reimburses at a rate of \$50/unit for anesthesia services (effective 01/01/09). This is more than twice that of the Worker's Comp rate. Note: The only physician services in the WC Program that are reimbursed at a rate less than the State Health Plan are Anesthesia Services.
- 6. **Problems with Processing Claims**. The WC system is slow to pay with the average A/R over 100 days. Claims that are not WC and subsequently filed with another carrier are denied for lack of timely payment because it took so long for WC to process and notify the provider that the claim was in fact not a WC claim. Too many claims are being filed hard copy, on the instructions of WC staff.
- 7. S.C. WC is the Lowest in the Southeast for Anesthesia Services. \*(see below)

• North Carolina rate: \$58.20/unit (MD gets 2/3 in MD/Nurse cases)

• Georgia rate: \$35.63/unit (MD gets 100% in MD/Nurse cases)

• Alabama rate: \$47.20/unit (MD/Nurse is 50/50)

• Florida rate: \$44.24/unit (MD gets 100% in MD/Nurse cases)

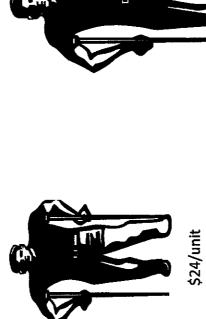
Median Managed Care rate: \$62.48/unit

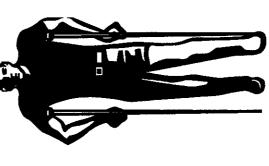
- 8. S.C. WC is out of compliance with HIPAA regulations. S.C. WC is not using the 2009 CPT codes for processing claims. HIPAA mandated that all insurance companies, payers and providers must use the current codes.
- 9. Since 2003, every payer has increased the anesthesia unit rate, except the S.C. Workers' Compensation Program. Even Medicare and Medicaid have had an increase.
- 10. The S.C. State Health Plan is perhaps the most comparable plan. The rate from S.C. Workers' Comp is only 48% of what the State Health Plan reimburses. (WC \$24/unit vs. State Health Plan \$50/unit).

## **Solutions**

- 1. Increase the unit rate to \$50/unit.
- 2. Split the MD/Nurse payment 60/40 for medically directed cases with an anesthesiologist and a nurse anesthetist.
- 3. Comply with HIPAA regulations.
- 4. Address late and slow payments.

# Worker's Comp vs. State Health Plan





Worker's Comp rates are 48% of the SC State Health Plan rates

\$50/unit

## Non-Parity in Reimbursement for Anesthesia Services Medicare vs. Commercial

## Commercial Insurance Rates

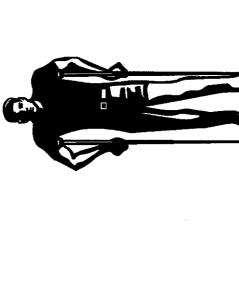
All Physicians Except Anesthesiologists

Anesthesiologists

## **Medicare Rates**

Anesthesiologists

**Except Anesthesiologists** 





## WORKERS' COMP AND ANESTHESIA REIMBURSEMENT

Presented by the SCSA
August 29, 2005 (2009 updates in red)

**CURRENT RATE: \$24.00/UNIT** 

HOW IS THE REIMBURSEMENT FOR ANESTHESIA CALCULATED? Base units plus time units multiplied by a conversion factor. Each anesthesia procedure is allotted a certain # of base units (as determined by the American Society of Anesthesiologists) plus the time involved in the operation or procedure, and then multiplied by the conversion factor.

WHAT IS A UNIT? A unit is x number of base units plus the measure of time involved in an anesthetic. Anesthesia time begins when the anesthesiologist begins to prepare the injured employee for the induction of anesthesia and ends when the anesthesiologist is no longer in personal attendance (e.g., when the injured employee may be safely discharged from the recovery area.)

HOW MANY MINUTES IN A TIME UNIT? In South Carolina, a unit is defined by the WC Commission as 15 minutes.

IS THIS THE SAME IN OTHER STATES? NO. Georgia uses a 10 minute unit; N.C. uses a 1 minute unit; Florida uses a 10 minute unit. Only a few other states, such as Alabama use a 15 minute unit.

WHAT DIFFERENCE DOES THE TIME MATTER? In a 60 minute period, there are more 10 minute units than 15 minute units. Thus, in one hour, six 10 minute units are equal to \$144.00, while four 15 minute units are equal to \$96.00.

HOW DID S.C. WORKERS' COMP DECIDE ON \$24.00/UNIT? The commission sets its rates on a percent of Medicare.

HOW DOES MEDICARE DETERMINE ITS RATES? Medicare uses several formulas to determine the reimbursement for physician providers.

ISN'T MEDICARE THE SAME FOR ALL PHYSICIANS? Absolutely not! In 1992, the Medicare Fee Schedule arbitrarily reduced the anesthesiology factor by 29% and again in 1998 the entire Medicare formula conversion was flawed with a resulting 54% reduction for anesthesiology.

HOW DOES MEDICARE COMPARE TO COMMERCIAL RATES? For all physicians, except anesthesiologists, the Medicare rate is between 71%-80% of commercial products. For Anesthesiologists (see previous answer) the percent of commercial is only 24%. 30%

HOW IS MEDICARE AS A PAYOR IN SOUTH CAROLINA? For anesthesiology, the Medicare conversion factor is in the bottom 2% of the nearly 250 Medicare Conversion Factors.

SO USING MEDICARE AS A BENCHMARK, BY DEFINITION CREATES A LACK OF PARITY BETWEEN ANESTHESIOLOGISTS AND ALL OTHER PHYSICIAN PROVIDERS? That's correct.

HOW DOES S.C. WORKERS' COMP COMPARE TO OTHER PAYORS IN THE MARKET? Only Medicare and Medicaid pay worse than S.C. Workers' Comp.

\$50.00

WHAT DOES THE STATE HEALTH PLAN PAY? \$45.00/unit, plus the state splits the payment 60/40 (MD/Nurse).

DOES S.C. WC PAY MOST PHYSICIANS COMPARABLY TO THE STATE HEALTH PLAN? Yes, except for anesthesiologists.

HOW DOES THE S.C. WORKERS' COMP REIMBURSEMENT COMPARE TO MANAGED CARE? The national average is \$50.00/unit and the state average is \$56.80/unit.

DIDN'T THE S.C. WC COMMISSION GIVE ANESTHESIOLOGISTS A 7% INCREASE IN 2002. WHILE GIVING ALL OTHER PHYSICIAN PROVIDERS A 5% INCREASE? Yes, and 7% of a much smaller number is far less than 5% of a larger number. Thus the 7% increase in 2002 was 4 times less than the 5% increase given to other physicians.

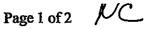
DON'T ANESTHESIA NURSES ALSO GET PAID BY THE COMMISSION? Yes.

DO THEY GET PAID A SMALLER PERCENT OF THE PHYSICIAN RATE? NO. In fact, before 1998, the nurses were paid 50% of the physician rate. In 1998, the S.C. WC Commission changed its methodology (without comment or input from the anesthesiologists or the SCMA) to a 50/50 split between the physician and the supervised nurse.

WHAT DID THIS DO TO THE AMOUNT REIMBURSED TO THE PHYSICIAN? The \$24.00/unit became \$12.00/unit.

WHAT DOES THAT MATTER SINCE THE PHYSICIAN EMPLOYS THE NURSE AND THE MONEY ALL COMES TO THE PRACTICE? Physician groups are employing fewer and fewer nurse anesthetists. Hospitals in South Carolina now employ more than 75% of the nurses.

DO OTHER PAYORS SPLIT THE FEE 50/50? Medicare does, but Medicaid does not and most commercial and managed care carriers do not. For example, S.C. BCBS splits the fee 65/35.



## **Medical Fee Schedule: Section 4**

## In Accordance with the N.C. Industrial Commission's Medical Fee Schedule & Subsequent Updates, 1996-2009

## **Bernadine Singh**

Chief Medical Fee Examiner N.C. Industrial Commission E-mail: Bernadine.Singh@ic.nc.gov

NOTE 1: To purchase a complete copy of the American Medical Association's Current Procedural Technology Codes, telephone Ingenix, Inc. at (800) INGENIX (464-3649), option 1, or go to http://www.shopingenix.com/modules/catalog/catalog\_category.asp to order a CPT® code book online.

**NOTE 2:** Please report any problems or errors directly to Bernadine.Singh@ic.nc.gov.

**NOTE 3:** This page was last revised on February 20, 2009.

## TABLE OF CONTENTS

Introduction CPT Codes and Fees / Commission Assigned Codes **Evaluation and Management Section 3** Physical Medicine Section 10 Anesthesia Section 4 (effective April 1, 2000) Chiropractic Fee Schedule Section 11 (effective March 1, 2001) **Surgery Section 5** Industrial Rehabilitation Section 12 (effective January 1996) Radiology Section 6 Dental Fee Schedule Section 13 (effective May 1, 2007) Hospital and Ambulatory Surgical Center Section 14 (effective July Pathology and Laboratory Section 7 15, 2002) **Medicine Section 8** Forms Section 16 (effective February 1, 2000) **Durable Medical Equipment/Supply Fee Schedule** (effective January **Special Services Section 9** 1, 2008)

## Anesthesia Section 4

\*\*\*The following anesthesia codes are to be approved based on fee per minute. (Effective April 1, 2000.)\*\*\*

## ANESTHESIA REIMBURSEMENT FACTOR

The Anesthesia conversion factor is equal to \$47.20 per unit. <u>Department of Industrial Relations</u>, Administrative Code Rule 480-5-5-.15(9) provides the guidelines for determination of units.

Effective: June 15, 2008

NCIC Code	Description	Allowance
ANT01	major, general or spinal, by anesthesiologist (first hour)	\$3.88 per minute up to and including 60 minutes
ANT01	major, general or spinal, by anesthesiologist (second hour and subsequent hours)	\$2.05 per minute beyond 60 minutes
ANT02	major, general or spinal, by Certified Registered Nurse Anesthetists (first hour)	\$2.55 per minute up to and including 60 minutes
ANT02	major, general or spinal, by Certified Registered Nurse Anesthetists (second hour and subsequent hours)	\$1.05 per minute beyond 60 minutes

Major, general or spinal anesthesia services should be distinguished by the the use of "Type of Service" code "7" on the CMS (HCFA) 1500 Form, and by the documentation of time (actual minutes) on the bill.

## **Note to Processors**

- Unusual monitoring services are not considered part of the basic anesthesia package. Codes 36620-36625 and 93503 are such codes, and may be billed in addition to the "ANT" codes.
- When billing for injections or other pain management procedures that are not considered part of a general anesthesia service, the appropriate CPT code should be used and reimbursed accordingly.
- Use of CPT code 01996 for daily management of epidural or subarachnoid drug administration is allowed. Reimbursement is \$130.00 per day.
- There are some items that have no CPT codes, such as any type of supply or minor anesthesia.
   These items must be entered as CPT code 99070.

N.C. Industrial Commission • Medical Fees Section 4337 Mail Service Center • Raleigh, NC 27699-4337 Telephone: (919) 807-2503 • Fax: (919) 715-0282 NCIC Home Page: http://www.ic.nc.gov/

GA

## ge@rgia.gov\*



## State Board of Workers' Compensation

Home > Publications > Fee Schedule > Medical

## Medical

The April 1, 2009, Georgia Workers' Compensation Medical Fee Schedule is available for purchase. Click on the link(s) below which will direct you to the website where you can place your order.

Be sure to check this website for any updates to each year's fee schedule as they will be posted here.

Some notable changes to the 2009 fee schedule are as follows:

- 1. Maximum allowable reimbursements (MAR) have all been recalculated.
- 2. CPT codes were updated with code additions, deletions and revisions in accordance with the AMA.
- 3. IME rates have increased to \$600.00 for the first hour and \$150.00 for each additional 15 minutes. Use state-specific code IME01 when billing for IME.
- 4. Physician Testimony/Deposition rates have increased to \$600.00 for the first hour and \$150.00 for each additional 15 minutes.
- Translation/Interpretation for physician and PE use during face-to-face Evaluation and Management visits use state-specific modifier TR. See detailed information in Section IV, pages 11 and 12 of April 1, 2009 fee schedule.
- 6. Transportation Ambulance and Air Services has been added to the fee schedule.
- 7. Non-Emergency Transportation reimbursements have increased by 1.7%.
- ★ 8. Anesthesia base rate has been increased to \$35.63.
  - 9. Home Health Services hourly rates have increased by 1.7%.
  - State-specific modifier -TR has been added in circumstances where an interpreter/translator is required during a face-to-face E/M services provided by a physician or PE.
  - 11. Medical Record copy reimbursement remains unchanged from 2008.
  - 12. Pharmacy reimbursement remains unchanged from 2008.

April 1, 2009 Medical Fee Schedule - Binder

April 1, 2009 Medical Fee Schedule - CD

**April 1, 2009 Medical Fee Schedule Updates** 

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00794	8 + TM
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00802	5 + TM
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## **Anesthesia**

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00872	7 + TM
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00882	10 + TM
00902	5 + TM
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00908	6 + TM
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# Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition RULE 69L-7.020, F.A.C.

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#### 3. Surgical team.

Reimbursement for a surgical team shall be made BR to each team member for each surgeon's surgical service. Each team member shall identify the specific procedure with modifier 66 added to the code.

#### C. Reimbursement for multiple procedures.

- 1. Reimbursement shall be made for all medically necessary procedures when more than one (1) procedure is performed during a single operative session.
- 2. Reimbursement for the primary surgical procedure shall be the MRA in Part B, Section XI in this manual or the agreed upon contract price.
- 3. Reimbursement for an additional procedure shall be made at fifty percent (50%) of the listed MRA in Part B, Section XI in this manual or the agreed upon contract price. The additional procedure shall be identified when modifier 51 is added to the code to indicate the performance of multiple procedures.

## D. Reimbursement for bilateral procedures.

- 1. Reimbursement shall be made for bilateral procedures that are performed during the same operative session.
- 2. Reimbursement for a bilateral procedure that contains the word "bilateral" in the descriptor shall be made at the listed MRA in Part B, Section XI in this manual or the agreed upon contract price.
- 3. Reimbursement for a bilateral procedure that does not indicate that it is bilateral shall be made when the procedure is billed twice as follows:
  - a. Reimbursement for the first procedure shall be made at the listed MRA, in Part B, Section XI in this manual or the agreed upon contract price.
  - b. Reimbursement for the second procedure identified by adding modifier 50 to the procedure code, shall be made at fifty percent (50%) of the listed MRA in Part B, Section XI in this manual or the agreed upon contract price.

## SECTION X: ANESTHESIA SERVICES.

- A. Reimbursement for anesthesia services shall be made to a physician or to non-physician anesthesia providers limited to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs) rendering services within scope of state licensure.
  - 1. Reimbursement shall be based on application of the following values, physical status modifiers and certain qualifying circumstances.

#### a. Basic value (BV) or base unit.

- (1) The usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry) are included in the BV.
- (2) When multiple surgical procedures are performed during an operative session, the BV for the anesthesia procedure with the highest value is billed and reimbursed.
- (3) The BV units, listed in Part A, Section XI under Anesthesia, for each anesthesia procedure code are used in calculating reimbursement.
- (4) When a surgeon provides regional or general anesthesia for a surgical procedure that he or she actually performs, modifier 47 is appended to the surgical code to indicate that the operating surgeon performed the anesthesia. Reimbursement shall be at the BV for the anesthesia service rendered.

#### b. Time (TM) units.

- Anesthesia time begins when the provider starts to prepare the injured employee for anesthesia care in the operating room or in an equivalent area and stops when the provider is no longer in personal attendance.
- (2) Anesthesia time shall be billed as the total number of minutes of anesthesia. For example, one (1) hour and fifteen (15) minutes of anesthesia must be billed as seventy-five (75) minutes of anesthesia.
- (3) The minutes of anesthesia must be converted into TM units as follows:
  - (a) For anesthesiologists, each ten (10) minutes of anesthesia time equals one (1) unit of anesthesia and each minute over a unit has a value of one-tenth (1/10) unit.
  - (b) For CRNAs/AAs, each fifteen (15) minutes of anesthesia time equals one (1) unit and each minute over a unit has a value of one-fifteenth (1/15) unit.
  - (c) For codes providing BV + TM, time units shall be calculated and added to the listed BV to determine the reimbursement for the anesthesia services.
  - (d) Only the BV units apply for codes without a TM unit after the base unit. For some anesthesia services, time is not reported additionally. Therefore, additional units of time are not calculated for these codes when determining reimbursement.

### c. Physical status modifiers.

(1) Anesthesia services shall warrant additional reimbursement for units based upon the injured employee's condition and the complexity of the anesthesia service provided.

(2) A physical status modifier shall be determined to rank the injured employee's condition. Additional reimbursement shall be based on the unit value for the specific physical status modifier.

Physical Status Modifiers		Unit Values
<b>P1</b>	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease	
	that is a constant threat to life	2
P5	A moribund patient who is not expected	
	to survive without the operation	3
P6	A declared brain-dead patient whose organs	
	are being removed for donor purposes	0

### d. Qualifying circumstances.

Anesthesia services, which are provided under particularly difficult circumstances, may warrant additional reimbursement for unit values based on unusual events. This subsection includes a list of important qualifying circumstances that impact the anesthesia service provided. These procedures are not reported alone but are reported as additional procedure numbers qualifying an anesthesia procedure for additional reimbursement. The listed unit value must be added to the basic unit values to obtain the reimbursement. List each of the following codes separately in addition to the procedure code for the primary anesthesia procedure.

Qualifying Circumstances		Unit Values
99100	Anesthesia for patient of extreme age, under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (specify)	2

- 2. Reimbursement for anesthesia services shall be made at the anesthesia reimbursement allowance (ARA) calculated using the BV and TM values listed in Part A, Section XI in this manual or the agreed upon contract price.
  - a. Methodology for calculating the ARA for procedures that are listed basic value (BV) + time (TM).
    - (1) Select the applicable anesthesia procedure code and basic value from the schedule in Section XI.

- (2) Determine the time units according to Section X.A.1.b.(3) (ten [10] minutes = one [1] time unit for an anesthesiologist and fifteen [15] minutes = one [1] time unit for a CRNA/AA).
- (3) Any minutes that exceed a whole unit are counted as partial units (fractions of units), such as one (1) minute is one-tenth (1/10) unit for an anesthesiologist and one-fifteenth (1/15) unit for a CRNA/AA.
- (4) Determine any additional units that are justified by the physical status modifiers or qualifying circumstances addressed above in Section X.A.1.c. and X.A.1.d.
- (5) Add the basic value, time units, physical status modifier and any applicable qualifying circumstances to determine the total anesthesia value.
- (6) Multiply the total anesthesia value by the conversion factor of \$29.49 to obtain the anesthesia reimbursement allowance.
- b. Methodology for calculating the ARA for procedures that are listed only basic value (BV) and no time.
  - Multiply the basic value by the conversion factor of \$29.49 to obtain the anesthesia reimbursement allowance.
- c. Methodology for calculating the ARA for monitored anesthesia care.
  - (1) Follow the guidelines, as applicable, in Section X.A.2.a. as though anesthesia was administered (basic value + time).
  - (2) Multiply the total anesthesia value by the conversion factor of \$29.49 to obtain the ARA.
- B. Reimbursement for medical direction of CRNAs/AAs by an anesthesiologist.
  - Reimbursement shall be made to the anesthesiologist only for direct supervision of anesthesia services which are provided by the anesthesiologist and billed under the name and license number of the physician-employer.
    - a. Reimbursement shall be made to an anesthesiologist for providing medical direction, including preoperative and postoperative evaluations or specific consultation to a CRNA/AA when necessitated by a specific procedure or condition(s) previously identified by the parties to the protocol, as required.
      - (1) When medical direction by an anesthesiologist is required, the CRNA/AA shall bill by appending the HCPCS Level II Modifier QX to the anesthesia procedure code.
      - (2) Reimbursement for a CRNA/AA requiring medical direction by an anesthesiologist shall be fifty percent (50%) of the anesthesia reimbursement allowance listed in Part A, Section XI in this manual or the agreed upon contract price.

- (3) Medical direction shall be billed by the anesthesiologist by appending the HCPCS Level II modifier QY to the anesthesia procedure code.
- (4) Reimbursement for medical direction by anesthesiologists shall be fifty percent (50%) of the anesthesia reimbursement allowance listed in Part A, Section XI in this manual or the agreed upon contract price.
- b. Reimbursement shall not be made to either the anesthesiologist or the anesthetist/anesthesia assistant until the insurer has received and reviewed the bill and anesthesia report from both providers.
- 2. No additional reimbursement shall be made for general supervisory services rendered by the anesthesiologist or other physician.
- C. Anesthesia services for which time units are not allowed.

CRNAs and AAs who provide anesthesia for which no time units are used to determine the ARA shall be limited to eighty-five percent (85%) of the ARA allowed for an anesthesiologist.



## Greenville Anesthesiology, P.A.

1007 Grove Road Suite B Greenville, SC 29605

Phone: 864-242-4602 Fax: 864-240-0129

J. Michael Evans, MD B.T. Kennerly, MD William J. Burk, MD Inho Yoon, MD Chris G. Boukedes, MD R. Alan Carithers, MD Richard F. Knox, MD J. Carson Johnson, MD Stuart P. Lane, MD Steven H. Pusker, MD Steven Z. Lysak, MD C. Wendell James, MD Mark D. Mathis, MD Randall D. Wilhoit, MD Mark E. Carithers, MD Stephen F. Lane, MD Harry C. Sherman, MD John P. Kim, MD Vernon E. Merchant, MD Trevor K. Smith, MD Jonathan P. Wright, MD Patrick F. Williams, MD Robert R. Morgan, MD Alan W. Smith, MD Wayne M. Gabriel, MD Rhett A. Dodge, MD Theodore E. Rothman, MD Vito A. Cancellaro, MD Carlos L. Bracale, MD

Richard J. Oeser, MD

Medical Services Division
Attn: Mr. Gary Thibeau
South Carolina Worker's Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Dear Mr. Thibeau:

I am writing on behalf of the thirty-one physician members of Greenville Anesthesiology, P.A. to urge you to consider a long-overdue rate increase in the unit value for our services. Our understanding is that you and the Commission will be revising the <u>Medical Services Provider Manual</u> in the near future, and we would appreciate your consideration of our request during this process.

The current rate of \$24/unit represents an enormous undervaluation of our services in numerous ways as you are undoubtedly aware via the meetings and conversations that you have had with members of our Society in recent years. It is significantly less than every other state in the Southeast, it is based on Medicare reimbursement rates that arbitrarily devalue our services relative to every other physician specialty practice, and it represents less than half of what we are paid via the South Carolina State Health Plan.

I know that you will be meeting with our representatives again in the near future, and I hope that you will take action during the upcoming revision to remedy the significant imbalance in Worker's Compensation rates for our specialty. Financial times are admittedly challenging, but that situation does not mitigate the fact that our reimbursement rates have languished for many years prior to this downturn.

Thank you in advance for your consideration, and if I may be of service or assistance in any way, please do not hesitate to contact me at (864) 242-4602.

Respectfully,

Robert R. Mofgan, Jr., M.D. Past President
South Carolina Society of Anesthesiologists

## PUBLIC HEARING on the MEDICAL SERVICES PROVIDER MANUAL

# SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

1333 Main Street Columbia, South Carolina

## CHAIRMAN COMMISSIONER ANDREA C. ROCHE PRESIDING

COMMISSIONER DAVID HUFFSTETLER

Friday, June 19, 2009 - 10:00 a.m.

WORKERS' COMPENSATION COMMISSION PUBLIC HEARING
TAKEN BEFORE CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND
FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR
OF 10:00 AM ON FRIDAY, JUNE 19, 2009, 1333 MAIN STREET,
COLUMBIA, SOUTH CAROLINA.

CORA ELLIS BRUTON, Independent Court Reporter 131 BROWNING COURT LEXINGTON, SC 29073 (803) 397-0189

## PUBLIC COMMENTS

JEFF McLEOD, PRACTICE ADMINISTRATOR PEE DEE ORTHOPEDIC ASSOCIATES

CARL BUTLER, CEO
LOW COUNTRY ORTHOPAEDICS &
SPORTS MEDICINE

REGINA HITCHCOCK DIRECTOR OF GOVERNMENTAL AFFAIRS SOUTH CAROLINA MEDICAL ASSOCIATION

FRASER COBBE, EXECUTIVE DIRECTOR SOUTH CAROLINA ORTHOPAEDIC ASSOCIATION

1	THE COURT: Good morning. It's about 10:01 and
2	today's date is Friday, June the 19th, 2009. My name is
3	Andrea Roche and I am chairman of the South Carolina
4	Workers' Compensation Commission.
5	We're here today on the Commission's public hearing
6	on the Medical Services Provider Manual.
7	Also here is Commissioner David Huffstetler.
8	The Commission is seeking comments on the current
9	fee schedule, including payment and billing policies.
10	The fee schedule sets the maximum allowable fees
11	physicians and other medical providers may be paid for
12	authorized services provided to a workers' compensation
13	patient. It does not include fees for hospital inpatient
14	and outpatient services, services which are included in a
15	separate schedule.
16	The next edition of the Medical Services Provider
17	Manual will be a complete revision and include updates to
18	evaluation and management services, anesthesia, surgery,
19	radiology, pathology and lab services, medicine and
20	injections, physical medicine, special reports, supplies
21	and durable medical equipment. All procedural codes and
22	prices will be updated.
23	The Medical Services Provider Manual, provided for
24	by Regulation 67-1302, is based on the Center for
25	Medicare and Medicaid Services Resource Based Relative

1	Value Scale, or RBRVS. RBRVS establishes a relative
2	value for most medical services and is a well recognized
3	and established method for determining price based on the
4	work involved, the expense associated with providing that
5	service, and malpractice insurance costs. RBRVS attempts
6	to insure that fees are based on the resources used to
7	provide each service and utilize one of the most
8	systematic methods for setting prices. The relative
9	value of each procedure is multiplied by a conversion
10	factor to arrive at the maximum allowable payment. The
11	Commission's current conversion factor is \$52.00.
12	All comments and recommendations are welcomed.
13	The hearing has now begun and we're happy now to
14	hear from anybody who would like to present.
15	Mr. Thibault, if you would check the lobby one more
16	time.
17	COMMISSIONER HUFFSTETLER: Madam Chair, am I correct
18	that notice is properly served in the State Register and
19	the other venues that we would normally use for a Public
20	Hearing?
21	MR. THIBAULT: It is. It was published in the State
22	Register last month and on the website. But I'll check
23	the hallway.
24	THE COURT: And I do believe we've gotten some
25	feedback from some groups that may be presenting written

1	comments. All right. It appears that no one has come
2	to speak today at the hearing. We are continuing to
3	receive written comments. All parties have until June
4	30th to submit written comments and we anticipate the
5	Commission will consider the revisions to the Medical
6	Services Provider Manual at its September 28th, 2009
7	business meeting. The effective date of the next edition
8	will be set at the September meeting and is likely to be
9	early 2010.
10	MR. THIBAULT: We have of course, Mr. Lightsey
11	joining us, but he just published a comment and won't
12	speak, and there's no one else in the lobby area.
13	MR. THIBAULT: Are you here for the Medical Services
14	Provider Manual hearing? I'll get you to sign in. Do
15	any of you want to speak?
16	COMMISSIONER HUFFSTETLER: Madam Chair, we started
17	on time and there was no one here. It appears we now
18	have some folks who have arrived for the hearing, and I
19	suggest that we revisit your opening comments to make
20	sure everyone hears it.
21	THE COURT: We'll start over. Good morning
22	everybody. My name is Andrea Roche and I am chairman of
23	the South Carolina Workers' Compensation Commission.
24	We welcome everybody to the Commission's public
25	hearing on the Medical Services Provider Manual.

With me also is Commissioner David Huffstetler
today.

The Commission is currently seeking comments on the current fee schedule, including payment and billing policies. The Fee schedule sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. It does not include fees for hospital inpatient and outpatient services, services which are included in a separate schedule.

The next edition of the Medical Services Provider

Manual will be a complete revision and include updates to

evaluation and management services, anesthesia, surgery,

radiology, pathology and lab services, medicine and

injections, physical medicine, special reports, supplies

and durable medical equipment. All procedural codes and

prices will be updated.

The Medical Services Provider Manual provided for by Regulation 67-1302, is based on the Center for Medicare and Medicaid Services Resource Based Relative Value Scale, or RBRVS. RBRVS establishes a relative value for most medical services and is a well recognized and established method for determining price based on the work involved, the expense associated with providing that service, and malpractice insurance costs. RBRVS attempts

1	to insure that fees are based on the resources used to
2	provide each service and utilizes one of the most
3	systematic methods for setting prices. The relative
4	value of each procedure is multiplied by a conversion
5	factor to arrive at the maximum allowable payment. The
6	Commission's current conversion factor is \$52.00.
7	All comments and recommendations are welcomed.
8	Has everyone who wishes to speak already signed
9	up to do so?
10	Commissioner Beck do you want to
11	COMMISSIONER BECK: I've got hearings to start here
12	in a few minutes. I'll just sit here and sort of slip
13	out.
14	THE COURT: Commissioner Scott Beck has also joined
15	us and he's in the middle of hearings in the other
16	hearing room, so he's going to sit in the back.
17	Thank you. All right. Mr. McLeod. Step to the
18	podium, please. Please state your full name and who you
19	represent.
20	JEFF McLEOD: Yes, my name is Jeff McLeod. I'm with
21	Pee Dee Orthopaedic Associates in Florence, South
22	Carolina. I'm here today to promote the fee schedule
23	increase, if one can be obtained. At Pee Dee Orthopaedic
24	Associates about 15 percent of our total volume is with
25	workers' compensation patients. In dealing with workers'

comp it is far more difficult from an administrative standpoint than from your regular patient load. At Pee Dee Orthopaedics I have three full time individuals that are fully dedicated towards workers' comp patients. I've got two workers' comp specialists who deal specifically with the Employees, the Employers, work notices, things of that nature. And I also have a full time billing coordinator with workers' compensation. So all in all I've got about \$150,000.00 in salary and benefits directly attributable to workers' comp patients.

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The benefit of surgical specialists is that it saves the entire process a great deal of money. I have a report that I will give you, but Dr. Savoy did a study regarding early referrals to surgical specialists. It was a retrospective study on 50 patients that had full thickness rotator cuff tears. That study was divided into two groups. Group one were those employees that had early referrals to surgical specialists and the second group had delayed referrals. The mean time out of work for the first group was 6.6 months. The mean time out of work for the second group was 17.1 months. Total average medical costs for the first group were \$13,513.00 and for the second group \$35,537.00. Work comp payments, which is described as Work Comp Support Plus Settlement Costs, for the first group was \$12,358.00; for the second group

1	\$65,373.00; a difference of a little over \$53,000.00.
2	Total combined medical expenses for both groups,
3	\$25,871.00 for those receiving early referrals; and
4	\$100,911.00 for the second group. So clearly his study
5	shows that early referrals to surgical specialists is
6	very crucial in: 1) reducing the amount of time that
7	employees were injured or out of work; and 2)
8	considerably lowering the medical expenses for those
9	patients. Now, in order for medical practices to be able
10	to provide that type of infrastructure to get those
11	patients back it is critical that we keep the fee
12	schedule where it is if we actually an increase would
13	be nice, because since it has been a number of years
14	since the last increase, inflation is catching up and for
15	practices that are not as large as we are it is very
16	difficult for them to maintain the infrastructure in
17	order to be able to support this type of patient volume.
18	So I would urge the Commission to increase the fee
19	schedule.
20	Thank you.
21	THE COURT: Thank you. Mr. Butler.
22	CARL BUTLER: I'm Carl Butler from Low Country
23	Orthopaedics and Sports Medicine in Charleston, South
24	Carolina and I'm just going to kind of follow the steps
25	of what Mr. McLeod says. We're a large practice as well,

approvals, the authorizations and all the paperwork that goes — every — pretty much every appointment that we have with the work comp patient you always have to follow-up almost double the work in that you have to sen information to the adjuster as well as to the Carrier, the insurance Carrier. And so it's a lot of duplicative work that goes on, and so it is very labor intensive to do work comp.  THE COURT: Do you know what percentage of y'all's business is workers' comp?  CARL BUTLER: Sure. We're at about 27 percent wor comp. We see a large volume of work comp in our practice, and we kind of cater to work comp. That's wh we have full time people just doing the front end.  THE COURT: Who's in y'all's practice?  CARL BUTLER: Physician wise? We've got Dr. Cox is a senior — Dr. McCoy, Dr. Spearman, Dr. Stovall, Dr. Zimlich, Dr. Jaskwhich, Dr. Patel, Dr. Burgoyne. And	1	and we too have about three full time employees just on
description of the solution of the solution of the solution of the solution of the adjuster as well as to the Carrier, the insurance Carrier. And so it's a lot of duplicative work that goes on, and so it is very labor intensive to do work comp.  THE COURT: Do you know what percentage of y'all's business is workers' comp?  CARL BUTLER: Sure. We're at about 27 percent wor comp. We see a large volume of work comp in our practice, and we kind of cater to work comp. That's who we have full time people just doing the front end.  THE COURT: Who's in y'all's practice?  CARL BUTLER: Physician wise? We've got Dr. Cox is a senior Dr. McCoy, Dr. Spearman, Dr. Stovall, Dr. Zimlich, Dr. Jaskwhich, Dr. Patel, Dr. Burgoyne. And	2	the front end that follow-up with really just getting the
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	19	a senior Dr. McCoy, Dr. Spearman, Dr. Stovall, Dr.
	20	Zimlich, Dr. Jaskwhich, Dr. Patel, Dr. Burgoyne. And
21 we've got four more coming on this fall.	21	we've got four more coming on this fall.
22 And so, just again, just to reiterate what Jeff is	22	And so, just again, just to reiterate what Jeff is
23 saying it is, it's a nice it's nice to have the fee	23	saying it is, it's a nice it's nice to have the fee
		schedule where it is. I was driving up with my business
25 office manager today and she said there are some fee		

1	schedules for the Codes that we utilize that are
2	actually under what some of our other payers pay. So I
3	would like to see some of those brought up to to be
4	more competitive as well, you know, as a possible
5	increase on the fee schedule.
6	Thank you. Any questions you guys have.
7	COMMISSIONER HUFFSTETLER: I didn't quite
8	understand. You said you send two you're double
9	reporting to the adjuster and the insurance company, but
10	the adjuster works for the insurance company. I'm
11	not sure I understand that.
12	CARL BUTLER: The claims adjuster, sometimes we'll
13	have to send them the notes as well, as well as sending
14	the claims to the Carrier.
15	COMMISSIONER HUFFSTETLER: But the adjuster works
16	for the Carrier. Who else? That's what I'm not
17	understanding. Who else at the Carrier gets the do
18	you send it to?
19	CARL BUTLER: You know go ahead.
20	MARILYN SIZEMORE: (OFFICE MANAGER - LOWCOUNTRY
21	ORTHOPAEDICS & SPORTS MEDICINE) I don't know whether I
22	can if I can say anything or not. What happens is in
23	the the adjuster wants the HICFA and the notes, so we
24	send it to them and then the say it's Companion.
25	. Companion also wants it to be sent to their Claims

1	Receiving address, so we have to send it twice. We
2	have to fax it everything to the adjuster and then we
3	have to mail the exact same thing to Companion or whoever
4	it may be. And then sometimes it's communication is a
5	problem because if the adjuster changes they don't tell
6	us. And then
7	COMMISSIONER HUFFSTETLER: Okay. Is Companion the
8	only one that asks for that?
9	MARILYN SIZEMORE: I'm sorry?
10	CARL BUTLER: Is Companion the only one that asks
11	for that?
12	MARILYN SIZEMORE: Oh, they all do it.
13	COMMISSIONER HUFFSTETLER: Okay.
14	CARL BUTLER: And then like she was saying a lot of
15	times our problems with it, the adjusters change and so
16	when the adjusters change they never forward the
17	information to the new adjuster so we have to send all
18	that stuff again to the new adjuster once we figure out
19	who the new adjuster is. And so it's just -
20	COMMISSIONER HUFFSTETLER: I mean I expect that
21	health insurance has adjusters changing, but my real
22	question was I think you've answered it. Frankly,
23	it's a little difficult to understand why the adjuster
24	works for the Carrier, why there would be another copy.
25	But I think you answered what I asked. Thank you.

	15
1	CARL BUTLER: It's a good question; right?
2	THE COURT: Thank you.
3	THE COURT: All right. Ms. Hitchcock.
4	REGINA HITCHCOCK: Good morning. My name is Regina
5	Hitchcock and I'm with the Medical Association and I
6	appreciate the opportunity to come before you today. I
7	am, with your permission, standing in for Dr. Will Floyd
8	who is a physician member of ours who Chairs our
9	Occupational Medical Medicine Committee and could not be
10	here today. I will actually relay Dr. Floyd's comments
11	to you now and will be happy to provide you a copy of his
12	comments as well.
13	COMMISSIONER HUFFSTETLER: Again, if I could. Are
14	you speaking on behalf of Dr. Floyd
15	REGINA HITCHCOCK: I am.
16	COMMISSIONER HUFFSETLER: or are you speaking on
17	behalf of the Medical Association?
18	REGINA HITCHCOCK: Well, actually both I guess. As
19	for the Medical Association
20	COMMISSIONER HUFFSTETLER: Because I had understood
21	the Medical
22	REGINA HITCHCOCK: and Dr. Floyd as a member.
23	COMMISSIONER HUFFSTETLER: I had understood the
24	Medical Association was taking no position on this.
25	REGINA HITCHCOCK: Well, I'm basically here

CORA ELLIS BRUTON, Independent Court Reporter (803) 397-0189

on behalf of the Association and relaying the comments from this Committee that Dr. Floyd Chairs.

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3 <u>COMMISSIONER HUFFSTETLER</u>: Are you representing the 4 Medical Association?

REGINA HITCHCOCK: To answer that quickly I would say I'm here for Dr. Floyd.

COMMISSIONER HUFFSTETLER: Thank you.

REGINA HITCHCOCK: Okay. The Occupational Medical Committee of the Medical Association is extremely proud of the service our physicians provide the workers' comp -- the workers of South Carolina under the compensation Other than the workers themselves, the physician's role is the most pivotal in this system. Ιt is the physicians who aggressively treat injured workers in an attempt to minimize permanent impairment and disability which are the real cost drivers in a workers' compensation system. In addition to making the best medical decisions and giving quality medical treatment which is the extent of what is needed to treat patients with Medicare or private insurance, the demands on a physician are much more in the workers' compensation Dealing with attorneys, insurance carrier's system. agents, return to workers' comp -- excuse me, return to work issues, including appropriate modified duty, providing fitness for duty evaluations, completing short

1	and long term disability paperwork; determining
2	impairment ratings, sittings for legal depositions, and
3	trying to meet employers' expectations; in addition to
4	providing quality care for the patient is what makes
5	providing workers' compensation care so much more
6	difficult. At the same time physicians have been
7	functioning in our system without dated codes and some
8	excuse me, in some cases no codes since 2003 as well as a
9	fee schedule which has not been upgraded in nearly seven
10	years. This includes almost seven years with no cost of
11	living increases that we must provide for our staff,
12	including nurses excuse me, increased costs of
13	supplies, malpractice rates and other overhead required
14	of operating a medical practice which has, of course,
15	increased significantly since 2003. It is at this point
16	that some of the best physicians, including most ENT
17	specialist and neurologist especially here within the
18	Columbia area won't treat South Carolina Workers'
19	Compensation patients. Our two closest neighbors Georgia
20	and North Carolina have both updated their Provider
21	Manual on an annual basis. Also in both of these states
22	the manual is available online easily accessible to the
23	physician user as well as both having changes made to the
24	various Codes in their manuals to conform to changes that
	are made in coding nationwide. The recommendation of the
25	are made in occaring

1	SCMA's Occupational Medicine Committee is that the
2	Compensation Provider's Manual be updated from its
3	current 2003 form. Specifically we would recommend;
4	Number 1, a task force of stake holders to be assembled,
5	including members of the SCMA's Occupational Medicine
6	Committee for the sole purpose of updating the manual.
7	Number 2,
8	COMMISSIONER HUFFSTETLER: Can I interrupt you one
9	second?
10	REGINA HITCHCOCK: Yes.
11	COMMISSIONER HUFFSTETLER: Because again I had
12	understood the Occupational Medical Committee was not
13	taking a position. Do you represent them?
14	REGINA HITCHCOCK: I am here for Dr. Floyd on behalf
15	of the Committee. I think that's the best answer I can
16	give you.
17	COMMISSIONER HUFFSTETLER: I take from that you do
18	not represent the Committee?
19	REGINA HITCHCOCK: Okay.
20	COMMISSIONER HUFFSTETLER: I'm just asking.
21	Sometimes I
22	REGINA HITCHCOCK: Well, and Dr. Floyd would have
23	been here in the capacity as Chair.
24	COMMISSIONER HUFFSTETLER: You'll forgive me, I have
25	a tendency to ask direct questions.

1	REGINA HITCHCOCK: Well, I'm glad you do. I'm
2	glad you do. Dr
3	COMMISSIONER HUFFSTETLER: Well, I take it from that
4	you represent you're here on behalf of Dr. Floyd, you
5	do not represent that Committee?
6	REGINA HITCHCOCK: That's correct.
7	COMMISSIONER HUFFSTETLER: Thank you.
8	REGINA HITCHCOCK: Yes, Dr. Floyd would have been
9	here as Chair of the Committee, so I'm representing him.
10	Also, Number 2, have a fee schedule for physicians that
11	increase cost of living increases for each of the various
12	Codes to account for cost of living, the cost of doing
13	business relative to the 2003 values; Number 3, have a
14	built in annual cost of living assessment; Number 4, have
15	the manual be made available online and easily accessible
16	for the physician user. This will also allow for fees
17	and Codes to be easily updated as needed and allow for
18	corrections to be easily made to the manual, if
19	necessary. And on behalf of the Committee of the SCMA,
20	thank you for your time and attention, and your
21	consideration. Thank you.
22	THE COURT: Thank you very much. Is it Mr. Cobbe?
23	FRASER COBBE: Thank you very much for this
24	opportunity. My name is Fraser Cobbe; I'm the Executive
25	Director of the South Carolina Orthopaedic Association,

ı	and I appreciate the opportunity to address the
2	Commission this morning on this matter. I'm not going to
3	duplicate a lot of the testimony that you've already
4	heard this morning from a number of the physician
5	practices, but I do want to make sure we go on the record
6	and say the South Carolina Orthopaedic Association does
7	support an increase in the fee schedule acknowledging
8	that the fees have not changed since 2003. So what that
9	means for our physicians is the same price you were paid
10	to fix a tibia back in 2003 is the same price they will
11	get paid, saying they'll be compensated in 2009. This is
12	something we're extremely concerned with as our costs of
13	overhead continue to go up and our reimbursement remains
14	static. In the long term that's just not sustainable to
15	our practices, so we would urge you to consider
16	increasing the fee schedule as you go through this review
17	process. I do also want to go on record and support some
18	of the recommendations from Dr. Floyd, including making
19	the fee schedule available online; some sort of annual
20	increase for inflation; and also the formation of an Ad
21	Hoc Committee to look at the fee schedule as well and
22	take a real direct targeted look at the fee schedule and
23	the Codes that are utilized and where the reimbursement
24	is currently. I will say there are examples across the
25	country of states that have lowered their fee schedule or

1	have not maintained them to a point that physicians do
2	pull back their participation in the program and that
3	increase costs the system as we have already heard in
4	testimony this morning. So I urge your support of an
5	increase in the fee schedule and would be happy to answer
6	any questions that you may have.
7	COMMISSIONER HUFFSTETLER: Could you extend on what
8	you just said, "physicians backing out"? I'm not
9	FRASER COBBE: Well, there's certain
10	COMMISSIONER HUFFSTETLER: I'm not sure what you
11	mean by that.
12	FRASER COBBE: Well, two examples come to mind. In
13	Texas a few years ago they lowered their fee schedule
14	from where it was existing and I believe they cut it back
15	to about 125 percent of Medicare and they there was a
16	number of studies that how the physicians could no longer
17	schedule workers' comp patients because the reimbursement
18	was so low when they're filling
19	COMMISSIONER HUFFSTETLER: Let me let me be a
20	little more direct because I was earlier. Again, I have
21	a tendency to be direct. I don't mean to be offensive,
22	just to be just try to get to the point. We had a
23	statement made at a senate hearing a couple of years ago
24	by some folks who purported to represent hospitals. I'm

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not saying the hospitals said this, but we had folks --

1	someone who made a comment that all the hospitals were
2	going to get together and just not treat workers'
3	compensation patients, which in my mind would violate the
4	antitrust laws. Is that what you're suggesting with
5	doctors?
6	FRASER COBBE: No, no. No, no. I'm saying, you
7	know, independent physician practices take a look at
8	their appointment schedule and they make, you know,
9	business decisions on how many patients of each type of
10	payor they can they can put together in their in
11	their practice. And so as all of the payors, you know,
12	adjust their fee schedules accordingly then the practices
13	make those independent decisions on scheduling, things
14	like that.
15	COMMISSIONER HUFFSTETLER: But you would agree with
16	me that it would not be proper for physicians to agree on
17	that?
18	FRASER COBBE: Absolutely.
19	COMMISSIONER HUFFSTETLER: Thank you.
20	THE COURT: All right, Mr. Cobbe, thank you so much
21	I think some folks came in after we started. Is anybody
22	else here that wishes to speak today.
23	COMMISSIONER HUFFSTETLER: Madam Chair, I see a
24	representative from the State Fund here. I'm looking to
25	see if there is anyone else here to represent the

business community, either the Chamber of Commerce or anyone from business, anyone from the insurance industry, self-insureds; is there anyone other than the State Fund who is a payor for this system who has appeared to give any input at all to this question? I see no hands.

THE COURT: I see no hands as well. All right,
thank you. If that is our last speaker then I'm going to
review --

COMMISSIONER HUFFSTETLER: There's someone in the back.

FRASER COBBE: I'd just like to recognize who came from around the state. Mary Elkins is here with the Carolina Orthopeadic Associates in Rock Hill, and also Ann Margaret with Midlands Orthopaedics. I would just mention that -- or recognize other of my colleagues.

THE COURT: All right. Thank you so much. All right. From this point forward the Commission is going to review all the comments that we received. In addition parties have until June 30th to submit written comments, if you'd like to do that as well. And we anticipate that the Commission is going to consider the revisions at its September 28th, 2009 business meeting. I can't promise that, but that's the anticipated date at this point. And the effective date of the next edition will be set at that meeting or whatever meeting we take it up and it's

1	likely to be in early 2010, to be the effective date of
2	the new manual. So if there are no further comments I
3	want to thank everybody for coming this morning, and the
4	hearing is now adjourned.
5	(The hearing adjourned at 10:28 a.m.)
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STATE OF SOUTH CAROLINA )
CERTIFICATE
COUNTY OF LEXINGTON )

BE IT KNOWN THAT I TOOK THE FOREGOING WORKERS' COMPENSATION HEARING;

THAT I WAS THEN AND THERE A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA-AT-LARGE;

THE FOREGOING TRANSCRIPT CONSISTING OF 22
TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND
COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT THE
TIME AND PLACE AFFORESAID TO THE BEST OF MY SKILL AND
ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

WITNESS MY HAND AND SEAL THIS 2ND DAY OF JULY, 2009.

CORA ELLIS BRUTON

NOTARY PUBLIC FOR SOUTH CAROLINA MY COMMISSION EXPIRES JANUARY 18TH, 2015.

## Attachment 4

Effect of Adopting 2009 Relative Values

Effect of Adopting 2009 Relative Values
Top 200 Workers' Compensation Procedures In South Carolina
Sorted by Total Expenditures

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Effect of Adopting 2009 Relative Values
Top 200 Workers' Compensation Procedures In South Carolina
Sorted by Total Expenditures

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	2003		85,822 82,992	74,881	106,089	63,904	119,948	72,727	80,415	37,071	84,476	62,389	60.063	59,660	63,546	46,286	53,839	42,170	62,996	72.827	56,600	20,592	69,842	59,111	69,752	74,415	74,412	82,695	62,899	71.286	51,542	68,195	63,066	54,578	54,975	51,751	71,383	56,553	42,195	55,385	50,742	54,142	52,404	45,714	38,000	79.526	35,354	48,780	21,083	28,314	40,330	40.135	33,376	41,693	47,807	35,414 48,798	40.181	35,997	41,847	31,949	
Total	2003		85,282 85,067	84,607	83,963	83,940	79,602	77,969	76,338	76,336	75,636	74,535	73.219	72,913	69,958	68,280	68,083	67,994	67.473 67.269	67.766	67,152	67,092	65,774	65,029	62.163	61,606	59,998	59,779	57,658		57 065	56,773	55,971	55.201	54,975	52,736	52,147	51,751	51,397	49,311	48,854	47,303	46,543	46,349	45,691	44 803	44,204	44,134	43,273	43,144	82,038 60,04	42.405	42,210	41,649	41,479	40,293	39,965	39,874	38,384	37,471	
		<u>s</u>	165 42	358	97	,121	. 57.	998	410	ē	55 :	<b>\$</b> \$	9 9	775	232	681	660'	989	8 48	247	159	143	<b>3</b> 5 (	142	742	8	827	£ :	4 :	Z (5	3 4	812	42	5,599	4 t	77.	247	496	753	420	2 ts	6	- 62	112	9/6	3 6	. g	33	166	378	7 6	542	244	1,985	Σ,	883	386	34	72	532	
	3:1 NF	ļ	3,18 0.80	88	40. 78.	.56	e. 2	92	.89				•																																											17.18					
	2 <u>8</u>	£ ]	<i>.</i>	4.43 e	1.87		1.10	16.65		1.29				_		13,09		_						1.76			₹	_		21.13	,	11.33		49.98 4		70 5			14.49 14		3.47				18.77		14.78		1.43		•		2.42			17.18				10,24	
es Se	NF Total		3.18 0.80	17.		21.56	79 73			2.16	<b>&amp;</b>	88			5.07		7	T	4		2.97				4 *		06	0.83			2 2	17.04		•	2.7	ري د د	4.75		•		25	96	1.52	2.16				.63	3.78		0.40	B)	5.44	••	1.36		£ 27	3.65	1.45		
2009 Refative Valu	ac Total NF		0.09 3				•										17		5 5						2 2		•																		<b>*</b> 8													_		85	
2009 R	Ιi	ı	33	_							ö,	5 6												0.35			o	Ö		9.70	<i>i</i> c	3.30			o i		2	ď	6.03		90		ici		6.98		7.78 T		0.37 0.		0 6		0.75			6.77	<b>5</b> C	0		4.28 0	
	S.	Facility		1.20	0.44		0.18	6.42	l	0.24			43.	2 60	ö	5.22	7.	<u>~</u>	0 0	ءَ مَ				0	ý 4	ř			•					14.98											9	.7	ď													4	
	Practice	Non-Facility	0.76	4.48	16.86	17.57		200	6.37	1,1	0.66	0.65	0.7		3.04	3			0,28	40 4	140	1.46	0.41	1.65		0.84	14.10	0.67	0.64	94	0.70	506	0.33		0,57	0.33	47.7	7.90		6,73	0.76	2.40	4.7.	1.13		***		0.27	2.72		4:0	96.0L	3.77		0.90	ì	0.00	9.00	1.07		
	Work	•	2.33	3.00	33	2.57	0.88	8 84	1.16	0.98	0.17	0.17	2 5	5.85	5 -	6.80	11.23	4,33	0.65	2.6	3 4	0.83	0.60	E 5	12.30 8 94	0.34	1,35	0.13	0.17	14.95	3 5	5.87	0.45	30.78	0.17	0.17	0.45	1.22	7,23	<b>1</b> .	0.22	0.20	0.31	0.96	10.05	7.15	97.0	0.35	1.00	3.00	0.25	<del>.</del> 6	54	21.73	0.42	9.00	9 6	0.18	0.31	5,11	
		36	45 43	465	1,457	1,473	88 5	0 6	88	208	4	<del>\$</del> ;	8 5	780	255	9	1,389	1,097	<u>.</u>	4, 6	189	466	20	536	5 5	8 8	299	ਲ	<b>4</b>	¥.	5 5	9,4	37	2,629	4	ខនុ	282	<u> </u>	918	327	47	5 5	₹ ₽	114	1,172	230	5 g	5 S	34	575	£	€ 6	308	1,983	20	937	335	\$ E	69	625	
alues	3:1 NF	EWU	3.16	7.79	28.02 1.48	28.32	0.73	14.38	7.49	4.00	0.77	0.77	6.63	18.01	2.4	19.31	26.72	21.09	860	18.22	9 6	96.89	0.97	55,5	2.5 5.5	1.01	12.82	0.60	0.77	27.71	200	13.00	0.71	50.55	0.77	47.0	2.0	8.73	17.65	6,28	9.0	5 5 6 6 6	35.	2.19	22.53	10.19	0,40	0.57	6.55	11.06	0,37	13.78	2 6	38.14	1.18	18,02	4. t	. c	£.	12.01	
2002 Relative Values	Facility	l		4.50	1.48	2	0.73	17 BG	2	1.30			1.57	10.01	2.45	19.31	26.72	21.09	0.98	18.22	1.88	3	0.91	1.81	21.45	17.30				27.74		12 12	0.71	50.55		0.44	5.48		17,65		ŗ	3.79			22.53	10.19	0.40	0.40	1.4	10.74	0.37	,	2011	38,14		18.02				12.01	
	on-Facility		3.16	88.88	28.02	28.32	:	14.58	7.49	4.90	0.77	0.77	<del>.</del>		5.73	2			0.98	5	4, 4 50, 6	96.8	0.99	5.46	5	2.2	12.82	0.60	0.77	į	0.7	12.33	0.71	i	77.0	0.44	5.77	8 73		6.28	0.91	0.4	1.35	2.19		;	0.40	0.57	8.27	11.17	0.37	13.78	7 17	:	1.18		6.44	, c	1,33		
Aggreg	ž		63.5%	64.0%	64.3%	64.8%	65.0%	65.2%	65.7%	65.9%	66.1%	66.3%	66.6%	67.0%	67.2%	67.4%	67.6%	67.8%	68.0%	68.2%	68.4%	58.8%	%0.69	69.1%	69.3%	69.0% 69.7%	%6'69	70.0%	70,2%	70.4%	70.5%	70.0%	71.0%	71.2%	71.4%	71.5%	71.7%	70.0%	72.1%	72.3%	72.4%	72.6%	72.6%	73.0%	73.1%	73.2%	73.4%	73.5%	288	73.9%	74.0%	74.1%	74.4%	74.5%	74.6%	74.7%	74.9%	75.0%	75.2%	75.3%	
**************************************	- 1		0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		0.2%		0.2%	0.2%	% X X	26.0	2 2 2	0.2%	0.2%	0.2%	0.2%	%2.0	2,0	0.2%	0.5%	0.2%	%2.0	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	2%	0.2%	0.1%	0.1%	0.1%	o c % ₹	0.1%	0.1%	0.1%	0.1%	2,5	2 2 2	0.1%	0.1%	%:	0.1% % %	3,7%	0.1%	0.1%	0.1%	0.7%	2 %	0.1%	
Angregate	Sum		21,717,254	21,886,928	21,971,436	22,139,340	22,218,942	22,297,791	22,373,760	22 528,434	22,604,069	22,678,704	22,752,966	22,826,185	22,089,090	22,369,030	23.105.418	23,173,413	23,240,884	23,308,152	23,375,418	23,509,663	23,575,436	23,640,466	23,702,928	23,765,091	23.886.695	23,946,474	24,004,131	24,061,768	24,118,945	24,176,010	24,288,754	24,343,955	24,398,929	24,453,178	24,505,914	24,558,061	24.661.209	24,710,520	24,759,449	24,808,303	24,855,606	24,948,498	24,994,189	25,039,759	25,084,562	25,128,766	25.112,500	25,259,317	25,302,376	25,345,369	25,387,774	25.471.633	25,513,112	25,553,405	25,593,590	25,633,556	25,073,428	25,749,284	
Total	CPT Code		85,282	84,607	84,508	83,940	79,602	78,849	78.338	76.336	75,638	74,635	74,262	73,219	518'7)	68,930	68.083	67,994	67,471	67,268	67,266	67.092	65 774	65,029	62,462	62,163	59.938	59,779	57,658	57,637	57,177	57 065	55 971	55,201	54,975	54,248	52,736	52,147	51 397	49,311	48,929	48,854	47,303	46,349	45,691	45,570	44,803	44,204	43 273	43.144	43,059	42,994	42,405	41.649	41.479	40,293	40,186	39,965	38.384	37,471	
7	lures		519	508	28	25	2,097	<u>\$</u> 2	\$ <del>2</del>	367	1,889	1,864	773	9 :	÷ į	7/4 68	8 4	62	1,324	7	295	200	1.304	275	8	, 1, 94	2 5	1.916	1,440	4	1,428	1,188 1,188	1.516	25	1,373	2,371	178	289	<u> </u>	151	1,034	238	1,096	407	39	98	2,154	9 4	1,403	22.	2,238	90	7.	<u> </u>	929	4	120	, 40,	595 595	8 8	
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	cription		<b>5</b> 6	ב לבו לך	ın L	w DYE	1	MRI,SPINAL CANAL/CONTENTS,TH	OKG,ABKA		щ	PE 3 VIEW	PY EVALUA	DVANCE-N	HUMB PRI		AKTHKUSCOPT WAIST	EXTEN TEN REPAIR, FINGER DORS	CHIROPRACTIC MANIPULATION	URG;SYNO		2	DOLOGICAL THERAPY RE-EVALUATI	L L/S ADD	POSTERIOR INSTRUMENTATION; W	TOOL MOIT	NO DAY	X-RAY FINGER OR FINGERS.MINI		SHOULDER ARTHROSCOPY/SURGERY	μĬ	X-RAY CHEST, TWO VIEWS;	IISSUE,MUS	. A	STRIOR			EINS	118	EA.WO		A.	STER	XTREM	TENODESIS FOR RUPTURE OF LON	PERCUT.IMPLANT-NEUROSTIMULAT		띪	One god	TEMPON SHEATH INCISION FOR T	Ā	LTIPLE	SEG	INJ PROCIMYELOGRAPHY/CLISPIN	7 VGN 4:	SUTURE OF DIGITAL NERVE, HAN	CT, LOWER EXTREMITY, W/O CONT	RAST	/IEW;	ξă	
	Procedure Description		ST PATIEN	SKOGRAPI	O.S. W/ DYI	NF WID &	ΜO	ANAL/CON	Y,KNEE,V	PSTHETIC	COMPLE	AINIMUM C	AL THERA	REPAIR!	FINGERAT	C/T	10 FO BO	EPAIR.FIN	C MANIPU	γ,KNEE,S	ICE VISIT	ESTAFING A	PAPY RE	EPIDURA	ISTRUME	AII.	TOUNDER	S OR FING	COMPLETE	RTHROSC	COMPLET	TWO VIE	ANECOS	CORPECTO	NTEROP		ZE E/M	EXTREM V	PINE WY DAY	ACIAL AR	CERVICAL	INTERVIE	ANTEROP(	LUMBUSA SPDHY/1 F	OR RUPT	ANT-NEU	SIS	PY SHOUL	010000	ATH INCIS	STMT-1 AR	3 (3D), MU	N.EXTRA	ELOGRAP TANKE		OGITAL NE	XTREMIT	WO CONTI	CERVICA	CERVILL. OSCOPY,	
	Pro		HOME VISIT, EST PATIENT	X-RAY SHUULUER, COMPLETE INJECTION DISKOGRAPHY	MRI BRAIN W/O & W/ DYE	SUBSICT HOSPITAL CARE	ER DPT VISIT LOW	SPINAL C.	HEOSCO	CTION AN	4Y ANKLE	AY HAND;	CUPATION	X.TENDON	AMPUTATION FINGER/THUMB, PRI/	INJECT SPINE C/T	AKTHKUSCOPT WAIST	EN TEN R	ROPRACT	THROSCO#	NEW E/M OFFICE VISIT	NUMBER HOLDS AND STREET	SICAL TH	INJ FORAMEN EPIDURAL LIS ADD	STERIOR II	REPAIR HERNIA	TOWER DELY	AY FINGE	AY FOOT	A NEDER A	AY WRIST	AY CHEST	SKIN, SUBCOLANEOUS LISSE BLVS PEDECOMANCE TEST	PETS PERFORMANCE IEST VEDTERBAL CORPECTOMY	X-RAY KNEE:ANTEROPSTRIOR	WHIRLPOOL	CRITICAL CARE E/M	DUPLEX SON EXTREM VEINS	CLLOMBAR SPINE W/DTE	CT, MAXILLOFACIAL AREA, W/O	X-RAY SPINE, CERVICAL	PSYCHIATRIC INTERVIEW	X-RAY KNEE;ANTEROPOSTER	X-KAY SPINELLUMBUSACKAL ELECTROMYORPHY/1 EXTRE	VODESIS F	RCUT.IMPL	IONTOPHORESIS	ARTHROSCOPY SHOULDER	MASSAGE	T T N T N T N T N T N T N T N T N T N T	YS MED TE	HEART IMAGE (3D), MULTIPLE	NE FUSIO	PROC MY	NEWSTELLICOLOR WIDECOM	TUREOF	LOWERE	PELVIC, V	SAY CHES	X-KAY SPINE,CERVICAL; KNEE ARTHROSCOPY, DX	
	•	1	₽ 5	įź	€ 5	<u> </u>	œ	œ	ž.	- ≒	ď	ıψ	Q	Η.	Σ	Ź Š	¥ij	2 2	苦	ĀR	Ű	Ž	í	₹	õ	E G	11 Q	¥ ×	×	ž	χ	×	2 5	£ 1	×	ş	ဗ	3 8	วิ จั	3 5	×	Š	× :	÷ 1	1 2	띰	ô	Ä	ž	Ź	급	빞	g.	ź¦	<u>د</u> ي	5 3	5	5	× >	žΖ	
;	Code	 		62290		39232 S				54476 U		73130 X	97003 C	26356 F			29840	26418	98941	29876	99205	64415	67007	64484	22842	49505	95904	23.40	3630	29806	73110	1020	11012	2 6	73560	.055	99291	93971	(2)32	70486	72040	90801	73562	05860	23430	63650	97033	29825	97124	23350	97012	78465	22614	2284	2020	83.1	73700	2192	1010	29870	

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Effect of Adopting 2009 Relative Values
Top 200 Workers' Compensation Procedures In South Carolina
Sorted by Total Expenditures

Column   C	1	2009 Change		30,009	28,172	42,399 29,798	18,262	32,888	40,984	24,530	41,251	46,589	19,369	26,414	33,415	32,086 20,840	32,105	18,957	35,963	29,245 32,595	18,743	27,247	28,371	35,327	28,507 27,820	25,628	31,537	15,715	23,149	16.016	27,812	18,448	21,869	32,996	49,575 24.464	18,203	31,326	22,786	26.874	30,239	20,432	22,664	21.776	23,194	17,056	25,833	1000
Part		2003		36,644	35,967	34,850	34,382	33,708	32,947	32,663	32,477	32,471	32,298	32,266	32,178	32,152	31,340	31,246	31,122	34,096	30,800	30,736	30,225	29,469	29,093 28,404	28,280	28,246 27,828	27,652	27,576	26.645	26,589	26,499	26,209	25,999	25,873	25,738	25,647	24,740	24.537	24,516	24,423	24,411	24.191	24,147	24 134	24,027	23.432
Column   C		NF	Price	517	1,761	20 28 88 88	630	<u>?</u> &	854	1,067	139	æ ;	807	111	393	1,783	\$ <b>4</b>	677	5	183	139	128	915 1.506	404	3 88 60	23	1,126	683	5 (	5,0,1 108	12	188	1.682	846	\$ 5	. F	729	8 8	2 8	1,043	1,075	<u>8</u> !	807	8	416	171 abc	343
Column   C			RVU	9.95	33.86	1.12	12.11	1.91	16.42	20.51	2.68	1.65	15.52	14.94	2.56	34.28	0.84	13.02	1.04	3.52	2.67	2.46	17.60 28.96	7.72	5.70	0.44	21.66	13.14	13.49	15.40	1.48	3,62	32.35	16.27	2.97	15.22	14.01	0.70	1.38 0.69	20.05	20.68	13.62	15.51	0.73	8.00	3.29	6.60
Column   C		Total Fac		9.95	7	19.76	12.11	1,65			2.68		15.52	14.94	;	34.28	0.90	13.02	4.0	2.69	2.88	1.89	17.60 28.96		1.47	0.24	21.66	13,14	13.49	15.40	1.08	9	32.35			15.22		,	1.13	17.81	20.68	13.62	15.51	2	8.00		4 51
Part   Product Description   Part	Values	l. i			33.86	1.12		1.99	16.42	20.51		1.65			7.56		0.84	i	į	3.79	2.60	2.65		7,72	1.78	0.50					1,61	3.62		16.27	2.97	6	14.01	0.70	5 6 6	20.80				0,73		3.29	7 6
### STATE CONTRICTORY SHALL BY A PARTY CATEGORY CATEGORY SHALL BY A PARTY CATEGORY CATE	9 Relative	l :		1.05	2.61	0.05 1.85	0.95	0.03	99'0	0.94	90.0	0.05	1.19	1.28	0.35	3.04	0.01	0.73	0.03	0,16	90'0	0.13	5,50	0.30	0.03	0,01	2.44	0.65	1.1	<u>5</u> .	0.07	0.26	5 2	0.45	0.08	0.95	0.48	0.03	6.0	1.28	1.87	0.83	0.10	50.0	0.55	0.13	0 20
Column   C	20		cillty	2.90	-	7 44	5.10	0.25			0.62	1	5.30	5,28		11.82	<u>,</u>	7,61	0.25	0.75	1.51	0.49	6.65		0.23	90.0	7.79	8.13	5.28	8.08	0.42	Ş	10.82	!		7.90		;	0.29	6.79	6.84	5.51	6.74	<u>.</u>	4.01		
OFF         TOTAL         Agenyale         Soft         Agenyale         <		Exp	1		26.93	0.85		0.59	14.28	17.42	!	1.00			6.02		0.38			1.85	1.23	1.25		6.33	\$.0°	0.32					0.95	2,53		14.47	2.72	0.04	11.61	0,50	0.62	9.78				0.53		1.62	0.3
CPT         TOTAL         Aggregate         S of Aggregate         S of Aggregate         S of Aggregate         Aggregate         S of		li	-1	6.00	4.32	10.22	909	37	1.48	2.15	2.00	0.60	2.70	8.38	1.19	19.42	0.45	4.58	0.76	1.78	2, 2,	1.27	9.45 15.98	1.09	1.21	0.17	11.43	4.36	7.10	10.95	0.59	0.83	9.6	1.35	0.17	6.37	1.92	0.17	0.75	9.74	11,97	7.28	2.56	0.17	3,44	1.54	76.0
Proceedings   Proceding   Pr			rice	632	2,248	1202	1,186	2 22	989	1.420	19	8	1346	949	379	1,786	4 4 5	1,116	47	46 5	228	44	975	335	90	32	000,	1,202	836	1,195	73	270	2016	299	25 6	1 119	296	<b>\$</b> :	88 F	845	1,285	763	155	8 4	583	159	202
Code   Procedure Description   Procedure   CPT Code   Sum   Todal   Scale   Aggregate	lues	3:1 NF	1	12.15	43.23	20.94	22.80	1.95	13.20	27.31	2.11	1.15	12.70 25.88	18.25	7.28	34.35	0.80	21.46	0.90	3.74	4.39	2.78	18,75	6.4	1.74	0,48	19.40	23.12	16.07	22.98	14.1	5.20	25.25 77.85	12.82	1.55	2. U.S.	11.47	0.76	8 8	16.26	24.72	14.67	2.99	0.76	11,32	3.06	2.0
Code   Procedure Description   Procedure   CPT Code   Sum   Todal   Scale   Aggregate	2002 Retative Vi	Facility		12.15	<u>.</u>	33 11	22.80	12.15		08.0	2.11	į	72.70 25.88	18.25		34.35	9. C	21.46	06.0	2.35	8.7. 7.7	1.68	18.75	?	1.64	0.24	19.40	23.12	16.07	22.98	1.06		13.29			21 52	1		1.20	16.25	24.72	14.67	2.99	67.71	11.32		
Code         Procedure Description         # Total         Aggragate         % of Aggragate																																															
Code		Facility			43.23	9. 76.		1 99	13.20	0.80	3	1.15			7.28		8	Ž,		27.50	5.28	3.14		6.44	1.77	0.56					1,53	5.20		12.82	1.55	96.0	11.47	0.76	1.77	16.26				0.76	2	3.06	5.18
COT         Procedure Description         Procedure Operation         Pr		- 1		.4%	·		%6;		•	•	•		.7%			.1%							%6:				3,4%	%C''	3.7%	3.7%			%0°0				_					%6.6	%0.0				
Code	Aggreg	%			75.6%	75.7%		76.0%	76.2%	76.3%	76.5%	76.6%		76.9%	77.0%		77.3%	77.4%	77.5%	77.5%	77.7%	77.8%		78.1%	78.2%	78.3%					78.9%	79.0%		79.2%	79.3%	79.3%	79.5%	79.6%	79.6%	79.8%	79.9%			80.1%	80.2%	80.3%	80.4%
Code	% of Aggreg	Total %		0.1%	0.1% 75.6%	0.1% 75.7%	20.0	0.1% 76.0%	0.1% 76.2%	0.1% 76.3%	0.1% 76.5%	0,1% 76.6%	0.1% % %	0.1% 76.9%	0.1% 77.0%	0.1%	0.1% //.2%	0.1% 77.4%	0.1% 77.5%	0.1% 77.5%	0.1% 77.7%	0,1% 77.8%	0.1%	0.1% 78.1%	0.1% 78.2%	0.1% 78.3%	0.1%	5.7 % 1.0	0.1%	0.0 % 5.	0.1% 78.9%	0.1% 79.0%	0 0 % %	0.1% 79.2%	0.1% 79.3%	0.1% /9.3%	0.1% 79.5%	0.1% 79.6%	0.1% 79.6%	0.1% /9.7%	0.1% 79.9%	0.1%	0.1% %1.0	0.1% 80.1%	0,1% 80.2%	0.1% 80.3%	0.1% 80.4%
CODE  103623 INSERT OR REPLACE OF SPINAL 20223 INITIAL HOSPITAL CARE 20230 INITIAL HOSPITAL CARE 20230 INITIAL HOSPITAL CARE 20230 INITIAL HOSPITAL CARE 20270 REPAIR TENDON/MUSCLE, EXTENSO 647718 ADJANTO THERAPY 20233 SUBJATO THERAPY 20234 RRI JOINT UPR EXT RWO & WI 20235 SUBJATO THERAPY 20235 RRI JOINT UPR EXT RWO & WI 20236 ARTHOOSPITAL CARE 20256 REPAIR TENDON/MUSCLE, TEXOR, 20256 REPAIR THOOSPITAL CARE 20256 ARTHOOSPITAL CARE 20256 ARTHOOSPITAL CARE 20256 STATIAL REPAIR HAND DORSUM, 20256 ARTHOOSPITAL CARE 20257 TEN REPAIR HAND DORSUM, 20258 ARTHOOSPITAL CARE 20258 ARTHOOSPITAL CARE 2021 SIMP REPAIR HAND DORSUM, 2026 ARTHOOSPITAL CARE 2021 INJECTION ANESTHETIC 2021 SIMP REPAIR HAND DORSUM, 2021 CARD AND ANESTHETIC 2021 SIMP REPAIR HAND DORSUM, 2021 CARD AND AND AND AND AND AND AND AND AND AN	% of Aggreg	Total %		0.1%	0.1% 75.6%	0.1% 75.7%	20.0	0.1% 76.0%	0.1% 76.2%	0.1% 76.3%	0.1% 76.5%	0,1% 76.6%	0.1% % %	0.1% 76.9%	0.1% 77.0%	0.1%	0.1% //.2%	0.1% 77.4%	0.1% 77.5%	0.1% 77.5%	0.1% 77.7%	0,1% 77.8%	0.1%	0.1% 78.1%	0.1% 78.2%	0.1% 78.3%	0.1%	5.7 % 1.0	0.1%	0.0 % 5.	0.1% 78.9%	0.1% 79.0%	0 0 % %	0.1% 79.2%	0.1% 79.3%	0.1% /9.3%	0.1% 79.5%	0.1% 79.6%	0.1% 79.6%	0.1% /9.7%	0.1% 79.9%	0.1%	0.1% %1.0	0.1% 80.1%	0,1% 80.2%	0.1% 80.3%	0.1% 80.4%
Code 6 63668   99223	Aggregate % of Aggreg	Sum Total %		25,785,929 0.1%	25,858,325 0.1% 75.6%	25,893,910 0.1% 75.7%	25,963,142 0.1%	25,997,259 U.1% 75.0%	26,063,914 0.1% 76.2%	26,096,612 0.1% 76.3%	26,161,752 0.1% 76.5%	26,194,223 0.1% 76.6%	26,226,583 0.1%	26,291,147 0.1% 76.9%	26,323,325 0.1% 77.0%	26,355,476 0.1%	26,386,926 U.1% //.2% 26,418,266 0.1% 77.3%	26,449,512 0.1% 77,4%	26,480,634 0.1% 77.5%	26,511,730 0.1% 77.5%	26,542,759 0.1% 77,5% 26,573,559 0.1% 77,7%	26,604,295 0,1% 77.8%	26,634,520 0.1%	26,693,983 0.1% 78.1%	26,723,076 0.1% 78.2%	26,779,760 0.1% 78.3%	26,808,006 0.1%	26,835,835 0.1% 26,863,486 0.1%	26,891,062 0.1%	26,918,546 0.1%	26.971,780 0.1% 78.9%	26,998,279 0.1% 79.0%	27,024,540 0.1%	27.076,748 0.1% 79.2%	27,102,620 0.1% 79.3%	27,128,429 0.1% /9.3%	27,179,814 0.1% 79.5% 1	27,204,553 0.1% 79.6%	27,229,096 0.1% 79.6%	27,253,533 U.1% /9.7% 27,278,150 U.1% 79.8%	27,302,573 0.1% 79.9%	27,326,984 0.1%	27,351,239 0.1%	27,375,430 0.1% 80.1% 27,399,578 0.1% 80.1%	27.423,711 0.1% 80.2%	27,447,738 0.1% 80.3%	27,471,172 0.1% 80.4%
655777657576767676767676767777777777777	Total Aggregate % of Aggreg	CPT Code Sum Total %	ļ	25,785,929 0.1%	35,967 25,858,325 0.1% 75.6%	35,585 25,893,910 0.1% 75.7%	34,382 25,963,142 0.1%	34,11/ 25,997,259 U.1% 76.0%	32,947 26,063,914 0.1% 76.2%	32,698 26,096,612 0.1% 76,3% 32,663 26,120,275 0.1% 76,4%	32,477 26,161,752 0.1% 76.5%	32,471 26,194,223 0,1% 76.6%	32,360 26,226,583 0.1%	32,266 26,291,147 0.1% 76.9%	32,178 26,323,325 0.1% 77.0%	32,152 26,355,476 0.1%	31,450 26,386,926 0.1% 77.2%	31,246 26,416,639 0.1% 77,4%	31,122 26,480,634 0.1% 77.5%	31,096 26,511,730 0.1% 77.5%	31,029 26,542,759 0.1% 77.5% 30,800 26,573,559 0.1% 77.7%	30,736 26,604,295 0.1% 77.8%	30,225 26,634,520 0.1%	29,469 26,693,983 0,1% 78.1%	29,093 26,723,076 0.1% 78.2%	20,404 20,731,440 0.1% 70.2% 28,280 26,779,760 0.1% 78.3%	28,246 26,808,006 0.1%	27,828 26,835,835 0.1% 27,652 26,863,486 0.1%	27,576 26,891,062 0.1%	27,484 26,918,546 0.1%	20,645 20,945,191 0.1% 78,5% 26,589 26,971,780 0,1% 78,9%	26,499 26,998,279 0.1% 79.0%	26,261 27,024,540 0.1%	25,999 27,076,748 0.1% 79.2% 1	25,873 27,102,620 0.1% 79.3%	25,809 27,128,429 0.1% /9.3%	25,647 27,179,814 0.1% 79.5%	24,740 27,204,553 0.1% 79.6%	24,543 27,229,096 0.1% 79.6%	24,537 27,253,533 0,1% /9.7% 24,546 27,278,150 0,1% 79.8% 1	24,423 27,302,573 0.1% 79.9%	24,411 27,326,984 0.1%	24,255 27,351,239 0.1%	24,191 27,375,430 0.1% 80.1% 24,147 27,399,578 0.1% 80,1%	24,134 27,423,711 0,1% 80,2%	24,027 27,447,738 0.1% 80.3%	23,434 27,471,172 0.1% 80.4%
$\begin{array}{c} 884 + 244 + 444 +$	Total Aggregate % of Aggreg	Procedures CPT Code Sum Total %		58 36,644 25,785,929 0.1%	168 35,967 25,858,325 0.1% 75.5% ·	728 35,585 25,893,910 0.1% 75,7%	29 34,382 25,963,142 0.1%	54 34,117 25,997,259 0.1% 76.0% as 33,708 26,030,667 0.1% 76.1%	48 32,947 26,063,914 0.1% 76.2%	786 32,698 26,096,612 0.1% 76.3%	296 32,477 26,161,752 0.1% 76.5%	543 32,471 26,194,223 0,1% 76.6%	49 32,360 26,226,583 0.1%	34 32,26 26,291,147 0.1% 76.9%	85 32,178 26,323,325 0.1% 77,0%	18 32,152 26,355,476 0.1%	64 31,450 26,386,926 0.1% //.2%	7.37 31,340 20,40,503 0.176 71.376 11	665 31,122 26,480,634 0.1% 77.5%	160 31,096 26,511,730 0.1% 77.5%	262 31,029 26,542,759 0.1% 77.5% 135 30,800 26,573,559 0.1% 77,7%	213 30,736 26,604,295 0,1% 77.8%	31 30,225 28,634,520 0.1%	88 29,459 26,693,983 0,1% 78,1%	322 29,093 26,723,076 0.1% 78.2%	1.133 28,779,760 0.1% 78.3%	28 28,246 26,808,006 0.1%	34 27,828 26,835,835 0.1%	33 27,576 26,891,062 0.1%	23 27,484 26,918,546 0.1%	20 20,945, 20,945,191 0.1% 76.5% 362 26.589 26.971,780 0.1% 78.9%	98 26,499 26,998,279 0.1% 79.0%	38 26,261 27,024,540 0.1%	39 25.99 27.076,748 0.1% 79.2% 1	321 25,873 27,102,620 0.1% 79.3%	517 25,809 27,128,429 0.1% /9.3%	43 25.647 27.179.814 0.1% 79.5%	. 626 24,740 27,204,553 0.1% 79.6%	VILIGAMENT/CYST, 290 24,543 27,229,096 0.1% 79.6%	749 24,537 27,253,533 0.1% 79.7% 20 24,546 27,278,150 0.1% 79.8% 1	19 24,423 27,302,573 0.1% 79,9%	32 24,411 27,326,984 0.1%	156 24,255 27,351,239 0.1%	27 24,191 27,375,430 U.1% 6U.1% 633 24,147 27,399,578 0,1% 80,1%	41 24,134 27,423,711 0,1% 80.2%	151 24,027 27,447,738 0.1% 80.3%	23,434 27,471,172 0.1% 80,4%

## **Attachment 5**

WCRI Medical Price Index for Workers' Compensation
The MPI-WC
Second Edition

Workers Compensation Research Institute Cambridge, Massachusetts

# WCRI MEDICAL PRICE INDEX FOR WORKERS' COMPENSATION, SECOND EDITION (MPI-WC)

Stacey M. Eccleston

with the assistance of:

Juxiang Liu

WC-08-29

June 2008

Workers Compensation Research Institute

Nonhospital Services	Overall	Emergency	Evaluation & Management	Major Radiology	Minor Radiology	Neurological Testing	Physical Medicine	Major Surgery	Surgical Treatment
Arkansas	103	83	96	107	85	85	101	89	124
Arizona <sup>a</sup>	105	110	87	100	100	100	106	103	83
California	96	99	74	77	78	115	109	91	70
Connecticut	124	138	104	108	130	161	92	160	92
Florida	94	79	88	71	72	73	80	102	122
Georgia	100	84	96	111	100	92	88	96	111
lowa <sup>b</sup>	130	154	110	155	128	136	114	130	138
Illinois <sup>c</sup>	161	205	121	163	183	167	148	167	160
Indiana <sup>b</sup>	133	185	110	122	161	152	125	127	145
Louisiana	96	125	99	105	109	94	99	73	99
Massachusetts	97	70	89	72	57	72	77	121	100
Maryland	76	78	90	70	63	77	84	49	87
Michigan	100	97	108	83	71	91	122	67	86
Minnesota <sup>a</sup>	111	140	122	123	104	101	115	80	115
Missouri <sup>b</sup>	126	168	113	125	152	133	107	131	129
North Carolina	90	98	82	95	85	72	91	77	95
New Jersey <sup>a,b</sup>	144	237	101	94	148	153	99	202	151
New York <sup>a</sup>	86	94	66	83	105	131	74	100	63
Oklahoma <sup>a</sup>	92	100	85	98	70	93	94	85	77
Pennsylvania	91	78	79	87	85	91	106	74	74
South Carolina	90	96	105	83	77	74	100	62	85
Tennessee <sup>c</sup>	113	130	117	114	100	109	96	110	128
Texas <sup>d</sup>	82	87	100	78	66	85	87	56	89
Virginia <sup>b</sup>	114	168	105	139	116	121	107	101	120
							4.5.5	544	104

<sup>&</sup>lt;sup>a</sup> The data for this state may be less representative than in other states because it is missing at least one dominant private insurer or state fund. To the extent that prices paid differ significantly for the missing payors compared to other payors in the state, this may bias the results up or down.

202

224

166

217

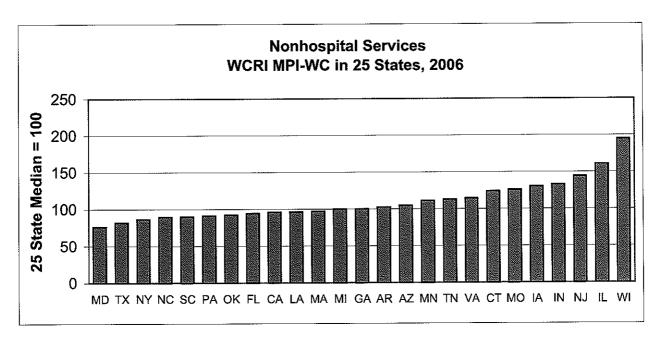
211

Wisconsin<sup>b</sup>

<sup>&</sup>lt;sup>b</sup> Denotes states without a workers' compensation fee schedule in 2006.

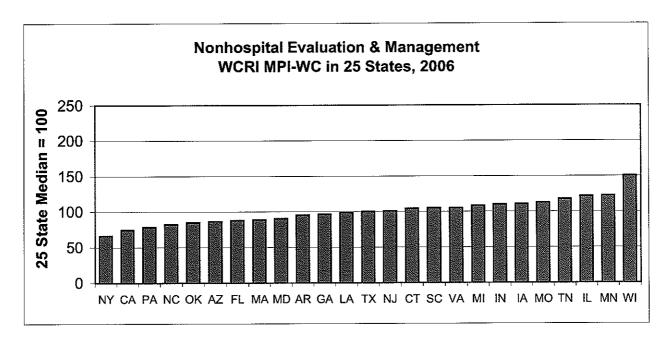
c Tennessee implemented a fee schedule in July 2005 and Illinois implemented fee schedules in February 2006.

d Texas increased its fee schedule effective in 2008.



#### Notes:

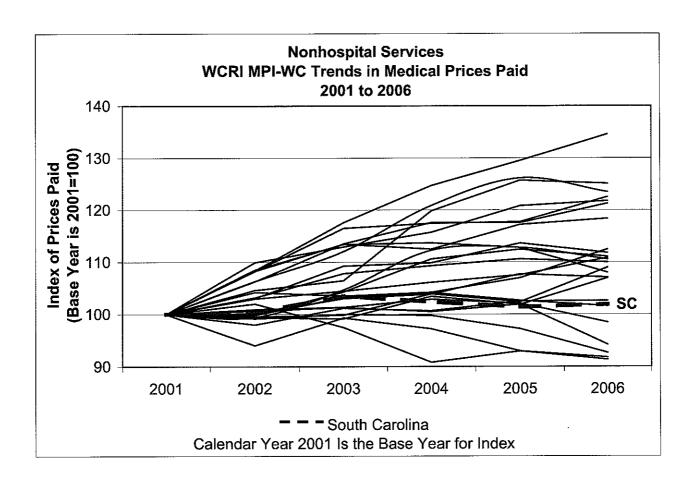
AZ, MN, NJ, NY, OK: The data for these states may be less representative than in other states because it is missing at least one dominant private insurer or state fund. To the extent that prices paid differ significantly for the missing payors compared to other payors in the state, this may bias the results up or down.

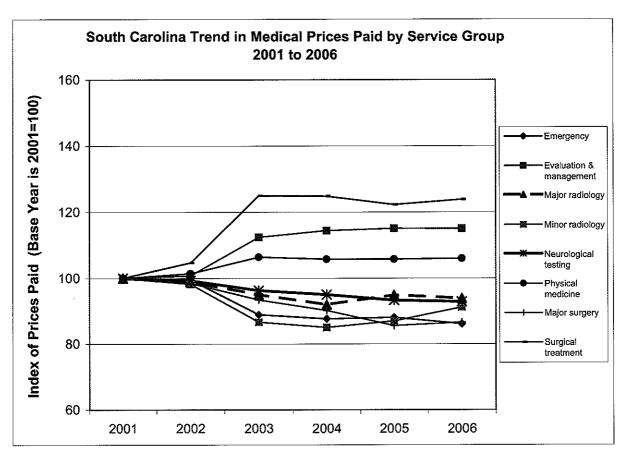


**Evaluation & management**: The services in this group are new and established patient office visits. These consist of an office or other outpatient visit which requires at least two of three parts: a problem focused history, a problem focused examination, and straightforward medical decision making of various complexities. See Table TA.2 for detailed description of all included services codes in this group.

#### Notes:

AZ, MN, NJ, NY, OK: The data for these states may be less representative than in other states because it is missing at least one dominant private insurer or state fund. To the extent that prices paid differ significantly for the missing payors compared to other payors in the state, this may bias the results up or down.





Nonhospital Services	2001	2002	2003	2004	2005	2006
Emergency	100	100	89	88	88	86
Evaluation & management	100	101	112	114	115	115
Major radiology	100	99	95	92	95	94
Minor radiology	100	98	87	85	87	91
Neurological testing	100	99	96	95	93	93
Physical medicine	100	101	106	106	106	106
Major surgery	100	98	93	90	86	87
Surgical treatment	100	105	125	125	122	124
Overall	100	100	103	102	101	102

2009 Geographic Adjustment Factors

2009 Geographic Practice Cost Indices by State and Medicare Locality

Centers for Medicare and Medicaid Services

ADDENDUM D: 2009 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality name	2009 GAF_
00831	01	Alaska	1.288
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1,201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
31143	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1,121
01192	17	Ventura, CA	1.121
00590	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.057
00590	03	Fort Lauderdale, FL	1.056
00524	01	Rhode Island	1.045
31143	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
00528	01	New Orleans, LA	1.017
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
04402	11	Dallas, TX	1.010
00511	01	Atlanta, GA	1.005
00590	99	Rest of Florida	1.001
31144	40	New Hampshire	0.996
00952	12	East St. Louis, IL	0.995
04402	31	Austin, TX	0.992
31142	03	Southern Maine	0.991
00973	50	Virgin Islands	0.991
04402	15	Galveston, TX	0.991

Contractor	Locality	Locality name	2009 GAF
00835	01	Portland, OR	0.987
12302	99	Rest of Maryland	0.987
04402	09	Brazoria, TX	0.985
04402	28	Fort Worth, TX	0.984
05302	02	Metropolitan Kansas City, MO	0.983
04102	01	Colorado	0.982
00883	00	Ohio	0.977
00836	99	Rest of Washington	0.977
03102	00	Arizona	0.974
31145	50	Vermont	0.973
05392	01	Metropolitan St Louis, MO	0.973
12502	99	Rest of Pennsylvania	0.970
00953	99	Rest of Michigan	0.969
00954	00	Minnesota	0.963
00904	00	Virginia	0.961
03502	09	Utah	0.960
04402	20	Beaumont, TX	0.959
00952	99	Rest of Illinois	0.956
04202	05	New Mexico	0.955
05535	00	North Carolina	0.953
04402	99	Rest of Texas	0.950
00630	00	Indiana	0.948
00835	99	Rest of Oregon	0.948
13282	99	Rest of New York	0.943
00528	99	Rest of Louisiana	0.943
00511	99	Rest of Georgia	0.943
00951	00	Wisconsin	0.942
00884	16	West Virginia	0.938
00880	01	South Carolina	0.937
05440	35	Теппезѕее	0.936
31142	99	Rest of Maine	0.933
05202	00	Kansas	0.932
05130	00	Idaho	0.932
00512	00	Mississippi	0.929
03602	21	Wyoming	0.927
00660	00	Kentucky	0.926
05402	00	Nebraska	0.923
05392	99	Rest of Missouri*	0.922
05302	99	Rest of Missouri*	0.922
05102	00	Iowa	0.922
03202	01	Montana	0.921
04302	00	Oklahoma	0.920
03402	02	South Dakota	0.918
00510	00	Alabama	0.917
00520	13	Arkansas	0.912
03302	01	North Dakota	0.908

Contractor	Locality	Locality name	2009 GAF
00973	20	Puerto Rico	0.837

GAF equation: (0.52466 \* work GPCI) + (0.43669 \* pe GPCI)+(0.038658 \* mp GPCI). GAF values contain a 1.000 floor on physician work GPCI (1.500 work floor in Alaska). \* Indicates multiple contractors.

ADDENDUM E: 2009 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality\*\*\*

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.853	0.496
00831	01	Alaska	1.500	1.090	0.646
03102	00	Arizona	1.000	0.957	0.822
00520	13	Arkansas	1.000	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	_1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	1.000	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
00590	03	Fort Lauderdale, FL	1.000	1.018	2.250
00590	04	Miami, FL	1.000	1.069	3.167
00590	99	Rest of Florida	1.000	0.939	1.724
00511	01	Atlanta, GA	1.009	1.014	0.836
00511	99	Rest of Georgia	1.000	0.883	0.829
01202	01	Hawaii/Guam	1.000	Ī.161	0.665
05130	00	Idaho	1.000	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	1.000	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	1.000	0.880	1.219
00630	00	Indiana	1.000	0.918	0.599
05102	00	Iowa	1.000	0.870	0.434
05202	00	Kansas	1.000	0.882	0.557
00660	00	Kentucky	1.000	0.860	0.652
00528	01	New Orleans, LA	1.000	1.044	0.956
00528	99	Rest of Louisiana	1.000	0.878	0.892
31142	03	Southern Maine	1.000	1.025	0.492
31142	99	Rest of Maine	1.000	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	1.000	0.982	0.874
31143	01	Metropolitan Boston	1.029	1,291	0.764
31143	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	1.000	0.923	1.083

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00954	00	Minnesota	1.000	0.983	0.245
00512	00	Mississippi	1.000	0.854	0.808
05302	02	Metropolitan Kansas City, MO	1.000	0.945	1.188
05392	01	Metropolitan St Louis, MO	1.000	0.931	1.075
05392	99	Rest of Missouri*	1.000	0.821	0.997
05302	99	Rest of Missouri*	1.000	0.821	0.997
03202	01	Montana	1.000	0.847	0.673
05402	00	Nebraska	1.000	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
31144	40	New Hampshire	1.000	1.039	0.462
12402	01	Northern NJ	1.057	1,228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	1.000	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
		Poughkpsie/N NYC Suburbs,			
13202	03	NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	1.000	0.921	0.425
05535	00	North Carolina	1.000	0.925	0.634
03302	01	North Dakota	1.000	0.844	0.387
00883	00	Ohio	1.000	0.927	1.232
04302	00	Oklahoma	1.000	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	1.000	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	1.000	0.925	1.081
00973	20	Puerto Rico	1.000	0.694	0.250
00524	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	1.000	0.906	0.446
03402	02	South Dakota	1.000	0.864	0.420
05440	35	Tennessee	1.000	0.889	0.608
04402	31	Austin, TX	1.000	0.984	0.969
04402	20	Beaumont, TX	1.000	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	1.000	0.953	1.110
04402	15	Galveston, TX	1.000	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	1.000	0.879	1.065
03502	09	Utah	1.000	0.907	1.026
31145	50	Vermont	1.000	0.983	0.489
00904	00	Virginia	1.000	0.942	0.657
00973	50	Virgin Islands	1.000	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	1.000	0.974	0.693

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00884	16	West Virginia	1.000	0.827	1.353
00951	00	Wisconsin	1.000	0.921	0.409
03602	21	Wyoming	1.000	0.842	0.889

<sup>\*</sup> Indicates multiple contractors.

<sup>\*\* 2009</sup> work GPCI reflects the 1.000 floor (1.500 floor in Alaska).

<sup>\*\*\* 2009</sup> GPCIs are the second year of the update transition and reflect the fully implemented updated GPCIs.

Workers' Compensation Premium Over Medicare by Service Group July 2006

Workers Compensation Research Institute Cambridge, Massachusetts

# BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 2006

STACEY ECCLESTON
TE-CHUN LIU

WC-06-14

November 2006

WORKERS COMPENSATION RESEARCH INSTITUTE
CAMBRIDGE, MASSACHUSETTS

Table 3 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule, by Service Group, July 2006

State	Р	Percentage Greater Than or Less Than Medicare Fee Schedule						
	Overail	Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management		
Alabama	83	203	77	42	47	12		
Alaska	236	417	273	287	153	127		
Arizona	73	163	89	59	39	13		
Arkansas	57	111	121	32	26	29		
California	21	56	5	46	13	-13		
Colorado	45	74	59	56	25	32		
Connecticut	99	253	114	132	25	27		
Florida	17	40	10	10	10	10		
Georgia	58	134	103	36	20	22		
Hawaii	10	10	10	10	10	10		
Idaho	108	249	159	98	25	85		
Illinois <sup>a</sup>	163	354	175	170	91	52		
Kansas	51	94	88	50	25	30		
Kentucky	48	106	34	23	30	28		
Louisiana	81	106	106	70	77	44		
Maine	65	75	63	41	64	65		
Maryland	15	36	6	7	9	7		
Massachusetts	-13	-6	-7	-5	-23	-4		
Michigan	33	33	33	33	33	32		
Minnesota	62	94	90	59	40	55		
Mississippi	81	131	83	51	71	44		
Montana	67	153	151	31	25	0		
Nebraska	93	186	164	50	48	43		
Nevada	105	207	166	56	67	24		
New Mexico	77	152	104	68	47	27		
New York	36	110	43	69	5	-19		
North Carolina	39	106	69	21	7	6		
North Dakota	45	72	87	29	30	14		
Ohio	43	96	45	18	37	-13		
Oklahoma	57	124	80	65	24	17		
Oregon	102	161	86	103	80	85		
Pennsylvania <sup>a</sup>	39	85	51	21	23	6		
Rhode Island	116	204	90	50	N/C	18		
South Carolina	47	58	48	26	45	46		
South Dakota	54	114	101	28	30	-2		
Tennessee	77	168	100	60	30	61		
Texas	25	25	25	25	25	25		
Utah	33	60	50	22	20	21		
Vermont	34	89	59	35	15	-17		
	43	43	43	43	43	43		
Washington	13	12	13	12	14	13		
West Virginia Wyoming	55	108	120	43	26	10		
wyoming Median state	55	106	82	43	26	23		

Key: N/C: noncomparable.

Note: General medicine is largely composed of neurology and neurological testing.

a Florida, Illinois, New York and Pennsylvania have distinct fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct substate fee schedules in 14 states. For each, we created a single statewide index using the same procedure.

Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

greater than the lowest. However, the highest workers' compensation fee schedule is 254 percent higher than the lowest. For example, the Medicare fee schedule rates in Connecticut and Massachusetts are, on average, 13 to 14 percent greater than the Medicare fee schedule rates in the median state. By contrast, the Massachusetts workers' compensation fee schedule is 32 percent less than the median state, but the workers' compensation fee schedule rates in neighboring Connecticut are 42 percent greater than the median state. Idaho is another example. The Idaho Medicare fee schedule is 5 percent lower than the Medicare fee schedule in the median state. However, the Idaho workers' compensation fee schedule (as revised in 2006) is 27 percent greater than the workers' compensation fee schedule in the median state.

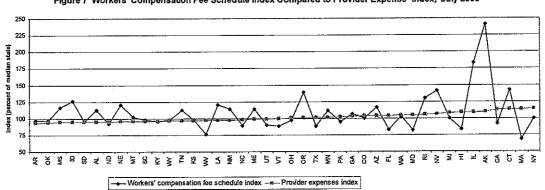


Figure 7 Workers' Compensation Fee Schedule Index Compared to Provider Expense index, July 2006

Notes: Florida, Illinois, New York, and Pennsylvania have distinct workers' compensation fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, we created a single statewide index using the same procedure. Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care. A few states follow the Medicare approach and avoid such incentives. If all services are reimbursed at the same premium over Medicare, the utilization incentives are neutral—not rewarding the provider more for the use of certain services over others. As can be seen from Table 3, few states have little or no difference in the relative reimbursement across service groups as they compare to

<sup>&</sup>lt;sup>a</sup> The provider expense index is based on Medicare's resource-based relative value scale which reflects the provider's costs to produce services.

Table 4 States with Workers' Compensation Fee Schedules That are at Least Double Medicare Fee Schedule Levels, July 2006					
Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management	
Louisiana (106)	Tennessee (100)	Oregon (103)	Alaska (153)	Alaska (127)	
Kentucky (106)	South Dakota (101)	Connecticut (132)			
North Carolina (106)	Georgia (103)	Illinois (170) <sup>a</sup>			
Wyoming (108)	New Mexico (104)	Alaska (287)			
New York (110) <sup>a</sup>	Louisiana (106)				
Arkansas (111)	Connecticut (114)				
South Dakota (114)	Wyoming (120)				
Oklahoma (124)	Arkansas (121)				
Mississippi (131)	Montana (151)				
Georgia (134)	Idaho (159)				
New Mexico (152)	Nebraska (164)				
Montana (153)	Nevada (166)				
Oregon (161)	Illinois (175) <sup>a</sup>				
Arizona (163)	Alaska (273)				
Tennessee (168)					
Nebraska (186)					
Alabama (203)					
Rhode Island (204) <sup>b</sup>					
Nevada (207)					
Idaho (249)					
Connecticut (253)					
Illinois (354) <sup>a</sup>					
Alaska (417)					
	ater than or less than M	edicare is in parenthese	es		
For each, we using employ	York and Pennsylvania created a single statew ment in each sub-state s in 14 states. For each	ide index by averaging region as weights. Med	the different sub- licare establishes	state fee schedules distinct sub-state	

procedure.

A few states may have fee schedules that are so low as to raise concerns about access to quality care. Again, this question cannot be definitively answered without additional outcome measures. However, policymakers should certainly pay attention to questions of access to primary care services in the states where the fee schedule rates are, at least, less than the Medicare reimbursement levels. There may also be concern in states

<sup>&</sup>lt;sup>b</sup> Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

schedule based on resource-based relative value scale and the relative value unit. This new fee schedule became effective on April 1, 2006. In fact, some states change their fee schedule rates annually. Table 6 lists the characteristics of the medical fee schedule and the latest effective date for each state. This study simply presents the comparisons of workers' compensation medical fee schedules to state Medicare fee schedules as of July 2006. It does not directly analyze the differences in the statistics presented in this version compared to the 2001/2002 edition. A future publication will likely focus on how these state rankings have changed from 2001/2002 to 2006.

Jurisdiction	Relative Value Scale Used	Last Effective Date of Fee Schedule and/or Conversion Factors
Alabama	The initial fee schedule was based on BC/BS RVS in 1992. It is annually adjusted no more then annual increase in cost of living as reflected by the US Department of Labor consumer price index.	May 19, 2006
Alaska	UCR. Senate Bill 130 limits fees to the fee schedule established by the workers' compensation board on December 1, 2004 through 2007.	December 1, 2004
Arizona		October 1, 2005
Arkansas	RBRVS	April 1, 2006
California	CRVS. For physician services rendered on or after July 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by 5 percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100-105% of the Medicare Rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. "OMFS Physician Services Fees for Services Rendered on or after May 15, 2005" lists the maximum reimbursable fee (=OMFS RVU x OMFS CF X reduction percent) for each individual procedure code.	May 14, 2005
Colorado	2005 RVP	January 1, 2006
Connecticut		May 1,2006
Florida	Medicare RBRVS: 40% above Medicare for surgery, 10% above Medicare for other procedures	April 28, 2006
Georgia	UCR	April 1, 2006
Hawaii	Medicare RBRVS: 10% above Medicare	January, 2006
Idaho	RBRVS	April 1, 2006
Illinois	Fee Schedule amounts were formulated by determining the 90% of the 80th percentile from healthcare provider fees from 8/1/02 through 8/1/04. Fee schedules were established for 29 geo-zips. An initial 4.96% increase was applied to the fee schedule amount for the period of 8/1/04 through 9/30/05. The Commission will automatically increase or decrease the maximum allowable payment based upon the CPI-U on an annual basis.	February 1, 2006
Kansas	RBRVS	December 1, 2005
Kentucky	2004 GPCI-adjusted RBRVS unit value	March 16, 2006

Jurisdiction	Relative Value Scale Used	Last Effective Date of Fe Schedule and/or Conversion Factors
Louisiana		March 1, 2004
Maine	RBRVS	July 1, 2002
Maryland	Medicare RBRVS: 44% above 2004 Medicare for orthopedic and neurological surgical procedures, 9% above 2004 Medicare except for orthopedic and neurological surgical procedures and the services rendered at ambulatory Surgical Centers	June 5, 2006
Massachusetts	The rates are determined by a regulatory process.	September 1, 2004
Michigan	RBRVS. Michigan creates their own RVU by adjusting GPCI from CMS	March 10, 2006
Minnesota		October 1, 2005
Mississippi	RBRVS	November 1, 2002
Montana	RVP	January 1, 2006
Nebraska	RBRVS. Nebraska uses GPCI adjusted relative value units.	July 1, 2006
Nevada	RVP	February 1, 2006
New Mexico		December 31, 2005
New York	New York relative value units	April 1, 2006
North Carolina	RBRVS	March 1, 2006
North Dakota	RVP	December 1, 2005
Ohio	RBRVS	January 1, 2006
Oklahoma	RBRVS	January 25, 2006
Oregon	RBRVS	April 1, 2006
Pennsylvania	RBRVS. Prior to January 1, 1995, the medical fees were capped at 113% of the Medicare. Medical fee update on and after January 1, 1995 are calculated based on the percentage changes in the Statewide average weekly wage annually. These updates shall be effective on January 1 of each year, and they are cumulative.	July 15, 2006
Rhode Island		July 1, 2006
South Carolina	RBRVS	January 1, 2003
South Dakota	RVP	June 14, 2006
Tennessee	Medicare RBRVS: 30% above Medicare for chiropractic care, 60% above Medicare for evaluation and management, 100% above Medicare for emergency care, radiology, and general surgery, 175% above Medicare for neurosurgery and orthopedic surgery. It must also be used with Medical Cost Containment Program Rules and the In-Patient Hospital Fee Schedule Rules.	May 1, 2006
Texas	Medicare RBRVS: 25% above Medicare	January, 2006
Utah	RBRVS	July 11, 2006
Vermont	A blend of several Blue Cross/Blue Shield fee schedules	May 15, 2006
Washington	RBRVS	July 1, 2006
West Virginia	RBRVS	January 1, 2006
Wyoming	RVP	September 30, 2005

Consumer Price Index – Medical Care South – Size Class B/C

Consumer Price Index – Medical Care Services South Urban

> Consumer Price Index - All Items South - Size Class B/C

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#### **Consumer Price Index - All Urban Consumers**

Series Id: CUURX300SAM

Not Seasonally Adjusted Area:

South - Size Class B/C

Item:

Medical care

Year	Jan	Feb	Mar	Apr	Mav	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
,		ļ	ļ		ļ							}	.,	···	
2003	121.7	122.5	122.9	123.1	123.2	123.1	123.8	124.1	124.5	124.8	125.9	126.0	123.8	122.8	124.9
2004	126.6	127.4	127.7	127.8	128.2	129.1	129.3	129.5	130.1	130.6	130.8	131.5	129.1	127.8	130.3
2005	132.2	132.9	132.9	133.2	133.5	133.8	134.4	134.6	134.7	135.0	136.3	136.4	134.2	133.1	135.2
2006	136.6	137.2	137.8	138.1	138.4	138.5	138.9	138.9	139.1	139.4	140.1	140.2	138.6	137.8	139.4
2007	140.387	142.109	141.460	141.751	142.481	142.804	143.346	144.277	144.353	145.654	146.931	147.269	143.569	141.832	145.305
2008	148.494	149.287	149.498	150.244	149.581	149.930	150.012	150.084	149.794	149.910	150.275	150.493	149.800	149.506	150.095
2009	151.196	152.531	152.605	153.317	153.367	153.392	153.459			Ĭ				152.735	

#### 12 Months Percent Change

Series Id: CUURX300SAM

Not Seasonally Adjusted

Area:

South - Size Class B/C

Item: Medical care Base Period: DECEMBER 1997=100

	Year Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Annual HALF1 HALF														
Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	4.5	4.6	4.7	4.7	4.6	4.3	4.0	3.9	3.7	3.5	3.9	3.7	4.1	4.6	3.8
2004	4.0	4.0	3.9	3.8	4.1	4.9	4.4	4.4	4.5	4.6	3.9	4.4	4.3	4.1	4.3
2005	4.4	4.3	4.1	4.2	4.1	3.6	3.9	3.9	3.5	3.4	4.2	3.7	4.0	4.1	3.8
2006	3.3	3.2	3.7	3.7	3.7	3.5	3.3	3.2	3.3	3.3	2.8	2.8	3.3	3.5	3.1
2007	2.8	3.6	2.7	2.6	2.9	3.1	3.2	3.9	3.8	4.5	4.9	5.0	3.6	2.9	4.2
2008	5.8	5.1	5.7	6.0	5.0	5.0	4.7	4.0	3.8	2.9	2.3	2.2	4.3	5.4	3.3
2009	1.8	2.2	2.1	2.0	2.5	2.3	2.3							2.2	

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#### **Consumer Price Index - All Urban Consumers**

CUUR0300SAM2 Series Id: Not Seasonally Adjusted South urban Area:

Item: Medical care services

Base 1	ase Period: 1982-84=100														
Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	292.6	294.4	294.8	294.9	295.6	296.1	297.4	298.1	298.8	300.5	303.5	304.3	297.6	294.7	300.4
2004	305.3	306.6	307.5	308.0	308.5	310.7	311.7	312.2	312.9	314.4	315.7	318.2	311.0	307.8	314.2
2005	319.7	322.2	323.8	324.7	325.3	325.5	326.5	325.9	325.9	327,4	330.4	329.8	325.6	323.5	327.7
2006	330.1	331.4	333.1	333.3	334.1	335.4	335.2	335.8	336.7	338.9	341.1	341.8	335.6	332.9	338.3
2007	343.987	347.926	347.352	347.587	349.616	349.983	351.396	354.150	354.858	357.688	359.569	360.243	352.030	347.742	356.317
2008	363.450	365.090	365.614	367.413	367.763	368.165	368.519	369.851	370.008	370.929	371.380	371.058	368.270	366.249	370.291
2009	372.150	374.400	374.813	376.106	376.267	376.567	377.263							375.051	

#### 12 Months Percent Change

Series Id: CUUR0300SAM2 Not Seasonally Adjusted

Area: South urban

Medical care services Item:

Base Period: 1982-84=100															
Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	5.6	5.8	5.3	4.8	4.7	4.6	4.5	4.4	4.2	3.9	4.4	4.3	4.7	5.1	4.3
2004	4.3	4.1	4.3	4.4	4.4	4.9	4.8	4.7	4.7	4.6	4.0	4.6	4.5	4.4	4.6
2005	4.7	5.1	5.3	5.4	5.4	4.8	4.7	4.4	4.2	4.1	4.7	3.6	4.7	5.1	4.3
2006	3.3	2.9	2.9	2.6	2.7	3.0	2.7	3.0	3.3	3.5	3.2	3.6	3.1	2.9	3.2
2007	4.2	5.0	4.3	4.3	4.6	4.3	4.8	5.5	5.4	5.5	5.4	5.4	4.9	4.5	5.3
2008	5.7	4.9	5.3	5.7	5.2	5.2	4.9	4.4	4.3	3.7	3.3	3.0	4.6	5.3	3.9
2009	2.4	2.6	2.5	2.4	2.3	2.3	2.4							2.4	

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Consumer Price Index - All Urban Consumers

Series Id: CUURX300SA0

Not Seasonally Adjusted

South - Size Class B/C Area:

Item: All items

Base	ase Period: DECEMBER 1996≔100														
Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	111.7	112.5	113.3	113.3	112.8	113.1	113.1	113.4	113.8	113.6	113.3	113.3	113.1	112.8	113.4
2004	113.8	114.3	114.9	115.6	116.4	117.0	116.9	116.9	116.9	117.4	117.4	117.1	116.2	115.3	117.1
2005	117.1	117.7	118.4	119.3	119.4	119.7	120.2	120.9	122.3	122.5	121.4	121.2	120.0	118.6	121.4
2006	122.0	122.1	123.0	124.1	124.6	125.0	125.5	125.4	124.4	123.7	123.4	123.8	123.9	123.5	124.4
2007	123.81	7 124.521	125.726	127.000	127.893	128.265	128.226	127.833	128.263	128.600	129.556	129.368	127.422	126.204	128.641
2008	129.93	7 130.351	131.442	132.516	133.714	134.980	135.643	3 135.004	135.093	133.285	130.324	129.099	132.616	132.157	133.075
2009	129.61	5 130.380	130.873	131.370	131.777	133.056	132.736	5						131.179	[

12 Months Percent Change

Series Id: CUURX300SA0

Not Seasonally Adjusted

Area: South - Size Class B/C

All items DECEMBER 1996=100 Base Period:

Year Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Annual HALF1 HALF2 1.8 **2003** 2.3 2.9 3.0 2.3 1.9 2.0 1.9 2.3 2.3 1.8 1.3 1.5 2.1 3.3 2004 1.9 1.6 1.4 2.0 3.2 3.4 3.4 3.1 2.7 3.3 3.6 3.4 2.7 3.7 **2005** 2.9 3.0 3.0 3.2 2.6 2.3 2.8 3.4 4.6 4.3 3.4 3.5 3.3 2.9 2006 4.2 3.7 3.9 4.0 4.4 4.4 4.4 3.7 1.7 1.0 1.6 2.1 3.3 4.1 2.5 **2007** 1,5 2.0 2.2 2.3 2.6 2.6 2.2 1.9 3.1 4.0 5.0 4.5 2.8 2.2 3.4 4.7 3.4 **2008** 4.9 4.7 4.5 4.3 4.6 5.2 5.8 5.6 5.3 3.6 0.6 -0.2 4.1 2009 -0.2 0.0 -0.4 -0.9 -1.4 -1.4 -2.1 -0.7

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Increase in the Medicare Economic Index Update for CY 2009

Centers for Medicare and Medicaid Services

is comprised of two broad categories: (1) Physician's own time; and (2)

physician's PE.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) Wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages

and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: Office expense; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector.

Table 32 presents a listing of the MEI cost categories with associated weights

and percent changes for price proxies for the 2009 update. For CY 2009, the increase in the MEI is 1.6 percent, which includes a 1.4 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.6 percent increase in physician's own time and a 2.4 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in prescription drugs, which increased 6.0 percent, and employee benefits, which increased 4.3 percent.

TABLE 32—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CY 2009 1

Cost categories and price measures	CY 2000 weights <sup>2</sup>	CY 2009 percent changes
Medicare Economic Index Total, productivity adjusted <sup>3</sup>	N/A	1.6
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector 3	N/A	1.4
Medicare Economic Index Total, without productivity adjustment	100.000	3.0
1. Physician's Own Time 4	52.466	3.6
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.8
b. Fringe Benefits: Employment Cost Index, benefits, private Nonfarm 4	9.735	2.7
2. Physician's Practice Expense 4	47.534	2.4
a. Nonphysician Employee Compensation	18.653	3.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	3.4
(2) Fringe Benefits: Employment Cost Index, fringe benefits, weighted by occupation	4.845	4.3
b. Office Expense: Consumer Price Index for Urban Areas (CPI-U), housing	12.209	3.1
c. Drugs and Medical Materials and Supplies	4.319	4.1
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI-		
U, medical equipment and supplies (equally weighted)	2.011	1.4
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	6.0
d. Professional Liability Insurance: Professional liability insurance Premiums 5	3.865	-2.7
e. Medical Equipment: PPI, medical instruments and equipment	2.055	0.5
f. Other Expenses	6.433	2.3

<sup>1</sup> The rates of historical change are estimated for the 12-month period ending June 30, 2008, which is the period used for computing the CY

These numbers may not sum due to rounding and the multiplicative nature of their relationship.

on the BLS Web site at http://stats.bls.gov.

5 Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2008).

#### C. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the percentage change in the MEI and the update adjustment factor (UAF). The UAF is applied to make actual and target expenditures (referred to in the statute as "allowed expenditures") equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

The PFS update is set under a formula specified in section 1848(d)(4) of the Act. Section 101 of the MIEA-TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF that was applicable for the first

half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

#### 1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following-

- · Prior Year Adjustment Component. An amount determined by-
- + Computing the difference (which may be positive or negative) between

<sup>2009</sup> update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 5, 2008.

2 The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

<sup>&</sup>lt;sup>4</sup> The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and CPIs can be found

Medicare Economic Index 2003 – 2009

**Centers for Medicare and Medicaid Services** 

# Medicare Economic Index 2003 - 2009

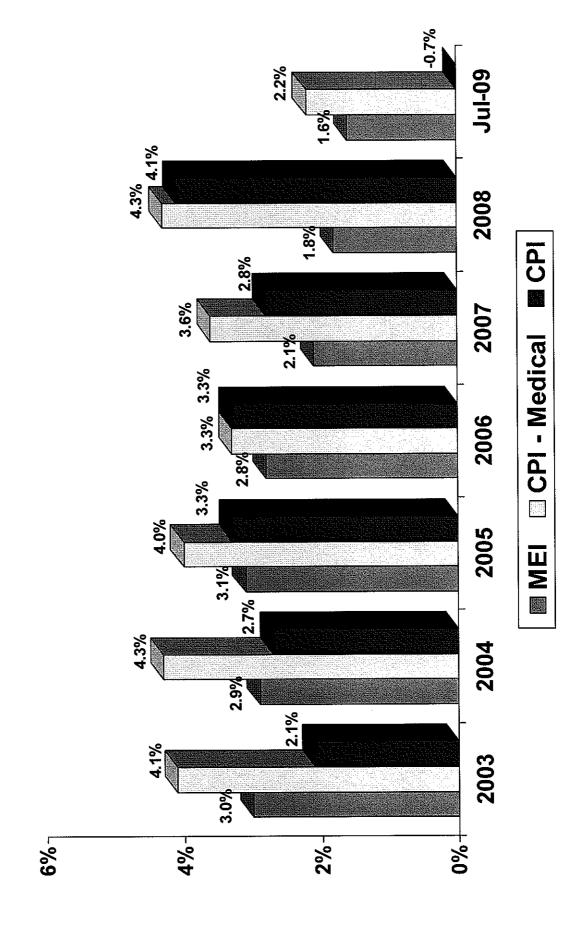
Year	Percent
2003	3.0
2004	2.9
2005	3.1
2006	2.8
2007	2.1
2008	1.8
2009	1.6

Medicare Economic Index Consumer Price Index – Medical Consumer Price Index 2003 - 2009

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# Medicare Economic Index & CPI 2003 - 2009



"Settlement to Reduce Brand-Name Drug Prices in Many States" Workcompcentral, September 1, 2009 Calculators

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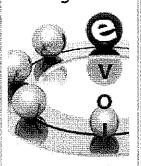
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### N/A -- Settlement to Reduce Brand-Name Drug Prices in Many States: Top 09/01/09

Insurers and employers in at least 32 states whose worker's compensation pharmacy fee schedules are tied to average wholesale prices are poised to enjoy a 4% reduction in the prices of brand-name drugs on Sept. 26, thanks to the settlement of a federal lawsuit against average wholesale price publishers First Databank and Medispan.

Some pharmacy benefit managers are scrambling to renegotiate contracts with payers because their reimbursement levels are tied to a percentage of the average wholesale price, industry experts say. Pharmacy benefit managers may even be pushed out of the market in states with exceptionally low drug fee schedules, such as Arizona, Kansas, Oregon, North Dakota, Massachusetts, New York, Washington and West Virginia, said Joe Paduda, owner of Health Strategy Associates.

"PBMs are being squeezed in the middle," Paduda said. "The states that I have heard about have given no indication that they are going to make any accommodation. New York was asked and Florida was asked and they said they are not going to do anything."

The reduction in published average wholesale prices stems from a lawsuit filed by the New England Carpenters Health Benefit Fund and several other parties against McKesson and its subsidiary, First Databank, filed in the U.S. District Court for Massachusetts. The unions accused the companies of colluding to artificially inflate the wholesale acquisition price of 1,442 drugs.

The average wholesale price is actually a misnomer. The benchmark measures what drug manufacturers charge to a buyer who makes a one-time purchase, while most buyers actually purchase drugs through long-term contracts at prices set far lower.

Historically, First Databank had derived the average wholesale price by surveying drug manufacturers to determine the wholesale acquisition price and multiplying by 120% or 125%, depending on the manufacturer's suggested markup. But starting in 2001, the company allegedly began using a 125% markup for all brand-name drugs, regardless of what the

manufacturer recommended, according to the lawsuit.

To settle the lawsuit, First Databank agreed to reduce the wholesale acquisition cost factor back to 120% for the 1,442 drugs that were subject to the lawsuit. Perhaps to avoid further litigation, the company later announced it would use the 120% multiplier for all drugs. Medispan, another average wholesale price publisher, also agreed to the same change in policy.

As a result, the average wholesale price of a drug with an average wholesale price of, say, \$125, will be reduced to \$120, or 4% less, on Sept. 26.

First Databank and Medispan have also decided to stop publishing the average wholesale price entirely in two years.

Generic drugs will not be affected because the wholesale acquisition cost was never used as a factor in the average wholesale price calculation, said Gregory Rucinski, president of the Tricast consulting firm in Milwaukee, Wis.

Rucinski said the National Association of Chain Drug Stores has threatened to file suit to block enforcement of the settlement terms, but its chances of success appear slim. He said drug retailers should be prepared to accept a 4% reduction in brand-name drug prices before the end of the month.

Rucinski said the settlement will have a much larger impact on group health care than workers' compensation, because worker's comp fee schedules are generally set higher than the contracted rates paid by group health care providers and government health programs, including Medicaid and Medicare.

"In many of those states it's a very fair rate to pharmacies," he said of workers' comp fee schedules in general.

But Paduda pointed out that some states already have very low fee schedule rates. New York, for example, recently adopted a fee schedule that sets drug prices at 75% of the average wholesale price for generics and 88% for brand-name drugs. Fee schedules in Arizona, Massachusetts and West Virginia cap drug prices at 85% of average wholesale price for both generics and brand-name drugs. Oregon's fee schedule caps brand-name drugs at 88% of the average wholesale price, while Kansas and Washington set the cap at 90%.

Paduda said pharmacy benefit managers (PBMs) in those states face severe reductions in reimbursement levels once the change takes place because their fees are based on the margin between the average wholesale price and any discounts they can get from pharmacies. He said pharmacies have been asking the PBMs to amend their contracts because of the reduction. The PBMs, in turn, will be forced to ask their clients to accept new contract terms.

"In some states, if the regulators aren't careful they may well squeeze PBMs out of the market," Paduda said.

In all, at least 32 states tie workers' compensation drug fee schedules to the published average wholesale price, according to data collected by CompPharma, a consortium of workers' compensation PBMs headed by Paduda. He said California's drug fee schedule is also tied indirectly to average wholesale prices because it is based on rates set by the state's Medi-Cal program, but the impact is more difficult to discern because California's fee schedule is much more complicated that other states.

So far, state regulators aren't promising any changes. Brian Keegan, spokesman for the New York State Workers' Compensation Board, said the board is aware of the coming change in average wholesale prices but has not decided on a course of action.

No one has yet asked the Oregon Workers' Compensation Division to change the state's drug fee schedule, said agency spokeswoman Lisa Morawski. "We go through rule making once a

year to set our fee schedule, and it is a lengthy process that involves quite a bit of public input," she wrote in an e-mail. "We generally don't make changes outside of that process."

To view court documents related to the federal lawsuit against McKesson, go here: http://www.mckessonawpsettlement.com/CourtDocuments.htm

By Jim Sams, Senior Editor jim@workcompcentral.com

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"Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010"

> National Council on Compensation Insurance, Inc. September 17, 2009

Impacts Due to Con	Impacts Due to Combined Changes in RBRVS and Anesthesia CF										
Service Category	Current CF	Proposed CF	Cost Distribution	Impact							
Anesthesia	\$24.00	\$30.00	2.9%	+25.0%							
Surgery	\$52.00	\$52.00	33.1%	-9.8%							
Radiology	\$52.00	\$52.00	17.1%	+8.2%							
Pathology and Laboratory	\$52.00	\$52.00	0.1%	+27.1%							
Medicine	\$52.00	\$52.00	3.2%	+10.7%							
Physical Medicine	\$52.00	\$52.00	22.0%	+6.5%							
Evaluation & Management	\$52.00	\$52.00	21.6%	+14.6%							
Impact on Physician Costs			100.0%	+3.8%							

		Impact (Change in RBRVS Only)	Impact (Combined changes in RBRVS and Anesthesia CF)
(1)	Impact on Physician Costs in South Carolina	+3.1%	+3.8%
(2)	Physician Costs as a Percentage of Medical Costs in South Carolina	41.0%	41.0%
(3)	Impact on Medical Costs in South Carolina = (1) x (2)	+1.3%	+1.6%
(4)	Medical Costs as a Percentage of Overall Workers Compensation System Costs in South Carolina	42.3%	42.3%
(5)	Total Impact on Overall Workers Compensation System Costs in South Carolina = (3) x (4)	+0.5%	+0.7%
(6)	Dollar Impact on Overall Workers Compensation System Costs in South Carolina	\$5.4M	\$7.6M



# ANALYSIS OF CHANGES TO THE SOUTH CAROLINA PHYSICIAN FEE SCHEDULE PROPOSED TO BE EFFECTIVE JANUARY 1, 2010

NCCI estimates that the adoption of Medicare's 2009 Resource Based Relative Value Scale (RBRVS), with no change to the conversion factor, would result in an increase of 0.5% (\$5.4M) on South Carolina's overall workers compensation system costs.

NCCI estimates that the combined impact of the adoption of Medicare's 2009 RB RVS and the proposed increase in conversion factors would result in an increase of 1.0% (\$10.9M) on South Carolina's overall workers compensation system costs.

#### **Background**

The current South Carolina physician fee schedule, effective since 2003, is based on 2002 Medicare RBRVS, with conversion factors of \$24.00 for anesthesia services and \$52.00 for services other than anesthesia.

The proposed South Carolina physician fee schedule, proposed effective 1/1/2010, is based on 2009 Medicare RBRVS, and increases the conversion factors to \$30.76 for anesthesia services and \$53.04 for services other than anesthesia.

NCCI was requested to separately quantify the impact due to the changes in R BRVS only; as well as the impact due to the combined changes in RBRVS and conversion factors.

#### Actuarial Analysis of Proposed Changes

NCCI's methodology assumes that the difference between the current and proposed Maximum Allowable Reimbursements (MARs) for each medical procedure is a reasonable estimate of the actual difference in costs due to the changes in reimbursements to the South Carolina physician fee schedule.

For each medical procedure, the MARs under the current fee schedule were calculated based on the **2002** Medicare RBRVS and the current South Carolina conversion factor. The MARs under the proposed fee schedule were based on the **2009** Medicare RBRVS and the proposed South Carolina conversion factors.

Procedures other than Anesthes ia

The formula used to calculate the facility and non-facility MARs for various medical procedures other than anesthesia under the current and proposed fee schedules are as follows:

Current Non-Facility MAR= [2002 Work RVU + 2002 Fully Implemented Non-Facility PE RVU + 2002 MP RVU] x Current South Carolina CF (\$52.00)

Current Facility MAR= [2002 Work RVU + 2002 Fully Implemented Facility PE RVU + 2002 MP RVU] x Current South Carolina CF (\$52.00)



Proposed Non-Facility MAR= [2009 Work RVU + 2009 Fully Implemented Non-Facility PE RVU + 2009 MP RVU] x Proposed South CF (\$53.04)

Proposed Facility MAR= [2009 Work RVU + 2009 Fully Implemented Facility PE RVU + 2009 MP RVU] x Proposed South Carolina CF (\$53.04)

Where: RVU = Relative Value Unit for Physicians,

PE = Practice Expense,

MP = Medical Malpractice insurance, and

CF = Conversion Factor

#### Anesthesia

For anesthesia procedures, the MARs under the current and proposed fee schedules were calculated using the following general formula:

Current MAR = (2002 Medicare Anesthesia Basic Unit + TVA) x Current South Carolina A nesthesia CF (\$24.00)

Proposed MAR = (2009 Medicare Anesthesia Basic Unit + TVA) x Proposed South Carolina Anesthesia CF (\$30.76)

Where: TVA = Time Value Amount (Each TVA is in 15 minute increments)

Under the current and propo sed fee schedules, the facility and non-facility costs for each procedure is the MAR for that procedure multiplied by the number of occurrences for that procedure<sup>1</sup>. Procedures for which no RVU is assigned in either the current or proposed Medicare RBRVS schedules are excluded from this analysis.

The estimated impact on costs subject to the physician fee schedule is the ratio of the total facility and non-facility costs of procedures under the proposed South Carolina physician fee schedule to the total facility and non-facility costs of procedures under the current South Carolina physician fee schedule. The direct impact of the proposed changes to RBRVS only is +2.7%. The direct impact of the combined changes to RBRVS and the increase in conversion factors is +5.4%.

For those procedures in which the fee schedule maximum was reduced<sup>2</sup>, the savings were adjusted to account for the anticipated increases in volume and shifts in the mix of services that will likely offset some of the reduction in fees. The magnitude of this adjustment is based on an analysis performed by the Centers for Medicare and Medicaid Services, which suggests that an increase in the volume and intensity of services is associated with a reduction in fee schedule reimbursement rates (refer to *Physician Volume and Intensity Response* on the CMS Web site at <a href="http://www.cms.hhs.gov/ActuarialStudies/downloads/PhysicianResponse.pdf">http://www.cms.hhs.gov/ActuarialStudies/downloads/PhysicianResponse.pdf</a>). This study suggests that any savings due to revising the schedule (other than for surgical procedures) would be offset by 30%-50%. In our analysis, the midpoint of 40% was used. No adjustment

<sup>&</sup>lt;sup>1</sup> Based on South Carolina workers compensation data licensed to NCCI, for service year 2007.

<sup>&</sup>lt;sup>2</sup> Fees were reduced for some procedures in every physician service category due to decreased relative value units under the 2009 Medicare RBRVS.



was made for surgical procedures because we assume these procedures do not incur an increase in volume and intensity of services due to a reduction in the re imbursement level.

The following table shows the breakdown of impacts on physician costs (after adjustment for shifts in mix and volume of services) by category as a result of the change in RBRVS only—i.e., using the current conversion factors (\$24.00 for anesthesia and \$52.00 for services other than anesthesia) for both current and proposed schedules:

Impacts Due to Ch	ange in RBRVS Only	
Service Category	Cost Distribution <sup>1</sup>	Impact
Anesthesia	2.9%	0.0%
Surgery	33.1%	-9.8%
Radiology	17.1%	+8.2%
Pathology and Laboratory	0.1%	+27.1%
Medicine	3.2%	+10.7%
Physical Medicine	22.0%	+6.5%
Evaluation and Management	21.6%	+14.6%
Impact on Physician Costs	100.0%	+3.1%

The estimated impact of +3.1% (due to the changes in RBRVS only) is then multiplied by the South Carolina percentage of medical costs that are subject to the physician fee schedule (41.0%)<sup>1</sup> to arrive at the impact of +1.3% on medical. The impact on medical is then multiplied by the percentage of South Carolina benefit costs that are medical costs (42.3%)<sup>3</sup> to yield a +0.5% (\$5.4M) impact on South Carolina's overall workers compensation system costs.

The following table shows the breakdown of impacts on physician costs (after adjustment for shifts in mix and volume of services) by category as a result of **the combined changes of RBRVS and increase in Conversion Factors**:

Impacts Due to Combi	ned Chang	es in RBRVS	and Conversion Fact	ors
Service Category	Current CF	Proposed CF	Cost Distribution <sup>1</sup>	Impact
Anesthesia	\$24	\$30.76	2.9%	+28.1%
Surgery	\$52	\$53.04	33.1%	-8.0%
Radiology	\$52	\$53.04	17.1%	+10.2%
Pathology and Laboratory	\$52	\$53.04	0.1%	+29.6%
Medicine	\$52	\$53.04	3.2%	+12.5%
Physical Medicine	\$52	\$53.04	22.0%	+8.5%
Evaluation & Management	\$52	\$53.04	21.6%	+16.8%
Impact on Physician Costs			100.0%	+5.8%

<sup>&</sup>lt;sup>1</sup> Based on South Carolina workers compensation data licensed to NCCI, for service year 2007

<sup>3</sup> Based on policy years 2005 and 2006 Financial Call data projected to 1/1/2010.



The above impact of the combined changes in RBRVS and conversion factors on physician costs is estimated to be an increase of 5.8%. This impact is then multiplied by the South Carolina percentage of medical costs that are subject to the physician fee schedule (41.0%) <sup>1</sup>to arrive at a +2.4% impact on medical costs. This impact on medical costs is then multiplied by the percentage of South Carolina benefit costs that are medical costs (42.3%) <sup>3</sup>to y ield a +1.0% impact on South Carolina's overall workers compensation system costs.

The impact due to the changes in the physician fee schedule, due to the change in RBRVS only as well as the combined change in RBRVS and conversion factors, is summarized in the following table:

		Impact (Change in RBRVS Only)	Impact (Combined changes in RBRVS and CFs)
(1)	Impact on Physician Costs in South Carolina	+3.1%	+5.8%
(2)	Physician Costs as a Percentage of Medical Costs in South Carolina <sup>1</sup>	41.0%	41.0%
(3)	Impact on Medical Costs in South Carolina = (1) x (2)	+1.3%	+2.4%
(4)	Medical Costs as a Percentage of Overall Workers Compensation System Costs in South Carolina <sup>3</sup>	42.3%	42.3%
(5)	Total Impact on Overall Workers Compensation System Costs in South Carolina = (3) x (4)	+0.5%	+1.0%

<sup>&</sup>lt;sup>1</sup> Based on South Carolina workers compensation data licensed to NCCI, for service year 2007

<sup>3</sup> Based on policy years 2005 and 2006 Financial Call data projected to 1/1/2010.